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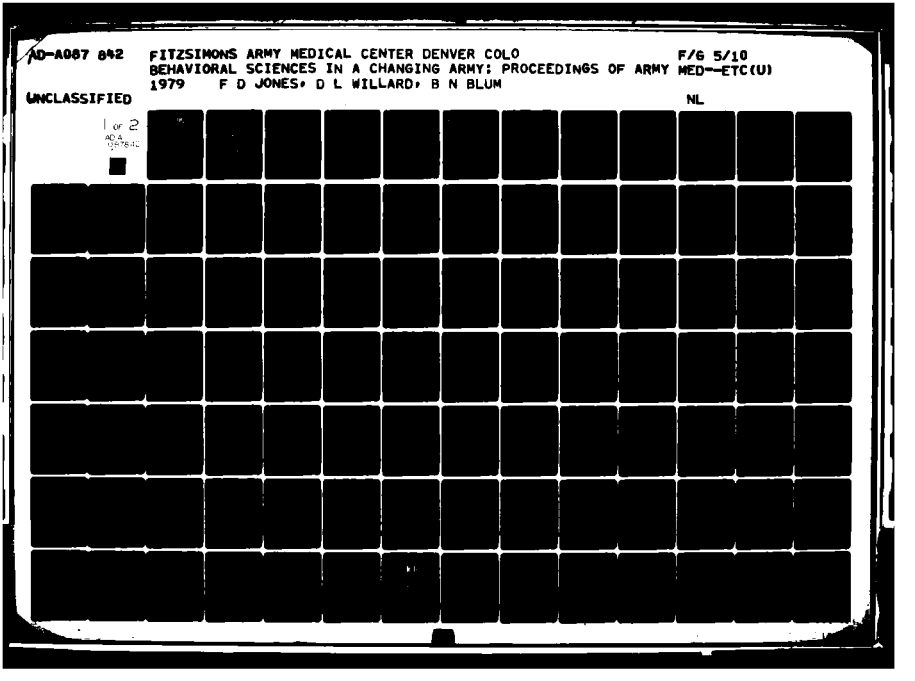

PROCEEDINGS OF (2)

LEVEL II

AMEDD BEHAVIORAL SCIENCES SEMINAR

19-23 MARCH 1979

fitzsimons army medical center

aurora, colorado 80045

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ABSTRACT

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Title: Behavioral Sciences in a Changing Army: Proceeding of Army Medical Department Behavioral Sciences Seminar, 19-23 March 1979 held at Fitzsimons Army Medical Center, Aurora, Colorado.

Authors: (10) Jones, Franklin Del / Jones
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These are the proceeding of a (now bi-annual) conference composed primarily of psychiatrists, psychologists and social workers in the U.S. Army. Presentations include the following: F.D. Jones - "Behavioral Sciences in a Changing Army" and "Valedictory: Response to the Task Groups (Leadership)"; V. Williams - "Behavioral Sciences - 30 year perspectives"; R.H. Gemmill - "Single-Parent Family: Active Duty and Dependent." Eight Task Groups reported on the following subjects:

Personnel Resource Management;
Training Issues; Revision of AR 40-216;
Alcohol and Drug Abuse, Recommendation for Action Regarding CHAMPUS Care for Mentally Ill; Women in the Army;
Legal Issues Pertaining to Involuntary Hospitalization of Military Personnel;
Sexual Variants and Deviations in the Army.

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BEHAVIORAL SCIENCES IN A CHANGING ARMY

PROCEEDINGS OF AMEDD BEHAVIORAL SCIENCES SEMINAR

19 - 23 March 1979

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0800 - 1600	Registration and Task Group Sign-Up

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0930	European Update LTC Richard MacDonald, MC, Consultant in Psychiatry, ESAEUR
1000	Break
1030	Task Group Leaders will outline the aims of their group
1145	Lunch
1315	Task Groups
1430	Break
1500	Task Groups
1630	Adjourn
1930	Cocktail Party Civilian attire is appropriate

WEDNESDAY, 21 MARCH 1979

0800	Administrative Announcements
0815	Task Groups
1000	Break
1030	Free University
1145	Lunch

1315	Task Groups
1500	Break
1530	Plenary Session
1630	Adjourn

THURSDAY, 22 MARCH 1979

0800	Administrative Announcements
0815	Task Groups
1000	Break
1030	Task Groups
1145	Lunch
1315	Task Groups
1500	Break
1530	Plenary Session
1630	Adjourn

FRIDAY, 23 MARCH 1979

0800 Task Group Reports

- 0800 Personnel Resource Management
- 0815 Training Issues
- 0830 Revision of AR 40-216
- 0845 Alcohol and Drug Abuse
- 0900 CHAMPUS Coverage of Psychiatric Problems
- 0915 Women in the Army
- 0930 Legal Issues Pertaining to Involuntary Hospitalization of Military Personnel
- 0945 Sexual Deviates in the Army

1000	Break
1100	Task Group Critique
1200	Adjourn

BEHAVIORAL SCIENCES IN A CHANGING ARMY

COL Franklin D. Jones, MD

Psychiatry and Neurology Consultant

Office of The Surgeon General

Department of the Army

Washington, DC 20310

General Deffer, Ladies and Gentlemen:

Although my title is "Behavioral Sciences in a Changing Army," it might just as aptly be entitled "A Changing Behavioral Sciences in the Army," since a major task of this conference is to take stock of such changes and make recommendations for updating regulations to meet the challenges of such changes.

Nearly 10 years ago I attended the first AMEDD-BS Conference here in Denver. The main purpose of the conference seemed to be the desire of the participants to define what a behavioral scientist is and is not. Particularly there was a need for each profession to explore its unique contributions to mental health care. The professions represented were diverse: the traditional triumvirate of psychiatry, social work and psychology were most strongly represented but also there were psychiatric nurses, occupational therapists, enlisted specialists, chaplains and even personnel from the disciplinary barracks.

Only the enlisted specialists, who had been newly christened behavioral sciences specialists, had no complaints about the name. The majority of others rejected the notion of being thought of as "B.S.'ers."

This rejection, I feel, was more than just an esthetic appreciation. Groups who were already struggling with identity problems were absolutely paranoid about the potential for identity diffusion and perceived loss of autonomy and prerogatives.

The psychiatrists voiced concerns about loss of control of resources and non-physicians performing medical procedures. The psychologists didn't want to be thought of as "junior psychiatrists" and the social workers, who rendered many services outside the psychiatric compass, were anxious to retain autonomous status outside departments of psychiatry. Psychiatric nurses were in the throes of defining roles outside traditional inpatient settings and all three major specialties were suspicious of them.

With these socio-psychodynamic forces in operation, it is not surprising that there was a good deal of acrimony, a great deal of hurt feelings, and a minimum of useful work accomplished. What is surprising is that the conference survived as an annual event.

I am bringing up this unhappy history because to paraphrase Santayana, if one ignores history, he is doomed to repeat it. There is evidence

that the failure to come to terms with these divisive issues has been detrimental to all of us as follows:

1. Several attempts to update AR 40-216, the basic regulation for neuropsychiatry have failed.

2. Civil war has erupted at several community mental health activities over issues of areas of responsibility, control and overlapping services.

3. We have had to function on the basis of compatible personalities rather than clearly delineated staff relationships.

4. Mutual sabotage of individual careers and programs has occurred.

5. Finally, and most importantly, we have been unable to stand united in combatting the erosions of benefits of our patients. Just one example of this failure is seen in the deprivation of CHAMPUS benefits caused by bureaucratic manipulation of payments. When care-givers must wait three to six months to receive reimbursement from OCHAMPUS, they refuse bill assignment and demand payment from the patient. If hospitalization is involved, they may request deposits of several thousands of dollars. At $50 or 60 per hour few can afford even outpatient care. Since there are not enough staff in the Army, these military persons are being denied care. Through a false distinction between treatment and

education, military children are not funded for learning disabilities, mental retardation and some forms of chronic psychosis. The rehabilitation of alcoholism, a disorder which may develop over a lifetime, is limited to one month. I noticed that few of us signed up for the CHAMPUS task force. I would urge reconsideration.

Another area of erosion is in false issue of civil rights, the right to refuse treatment as a banner cry allowing society to give up responsibility for the care of the mentally afflicted. State legislators love this development. It allows them to withdraw funding for costly hospitals with professional staff and pay small amounts for boarding mentally ill persons in newly created ghettoes of madness. We need a new Dorothea Dix to prick the consciences of our law givers and budget masters. Again the task force on Legal Issues is undersubscribed. Your expertise is needed.

We live in a rapidly changing Army. Since the hippie era drug abuse and alcohol abuse in the young have been rampant. The end of the draft and the feminist movement have forced us to reconsider not only who can do the job but also what jobs should be done. With a small, expensive, more feminine and greatly civilianized armed forces we seem more cautious about overseas adventures, more prone to rely on accommodation, technology and nuclear deterrence in our defense.

Feminization has allowed us to be a smarter Army with more high school graduates than ever, but it has also produced some problems. A new form of strain between commanders and those commanded has been the erotization of such relationships.

Women commanders have sometimes found immature male soldiers unable to see them as authorities while male commanders have been accused of sexual exploitation of female soldiers. The war of the sexes continues to be fought even when the soldiers wear the same uniform. We must contend with casualties from menstrual discomfort and pregnancy. The advent of large numbers of single parent families particularly with female parents is also a new phenomenon. Another new phenomenon coincident with synthesis of sex hormones and sophisticated surgery is the ability of people to alter their sexes, at least superficially. There is much ambiguity in the law as to the status of such persons, an ambiguity also related to other sexual deviates. How should we handle excellent soldiers found to be homosexual? My wife suggested that we should actively recruit them since they are an economic bargain. She pointed out that they would not be encumbered with dependents requiring medical care and special consideration in assignments. I doubt, however, that this idea would be very acceptable, even in the liberal mental health circles! Seriously, though, recent appelate decisions in the Matlovich and other cases have forced us to rethink our blanket

rejection of homosexuals.

All of these areas are worthy of our study and recommendations. They require our efforts to educate not only ourselves, our commanders and peers but also our student professionals and later the general public.

Recently having been Director of Psychiatric Education at WRAMC, I still consider myself an educator and see that as the primary role of a consultant. I was glad to see that the Educational task force has attracted a group of talented and enthusiastic professionals. The explosion of knowledge in biological and social areas is a great challenge to teachers who may have ten times the data to transmit in the same traditional intern and residency time frame as that when they were interns and residents. The total knowledge is not only greater but also it must adapt the trainee to changing missions and roles. When I was a resident, I was chagrined at the recent (then) separation of child psychiatry as a separate specialty, the same chagrin, I'm sure, felt by the generation ahead of me when neuropsychiatry split into neurology and psychiatry. Now a further splitting into subspecialties of administrative and forensic psychiatry has occurred, and community and psychopharmacology subspecialties loom in the near future.

This is, of course, one way to handle large amounts of data. Another way is to discover unifying principles which always simplify data. It

is with this hope of synthesis that I personally do not favor the development of a military psychiatrist or other professional subspecialty. After all, it was not the highly specialized dinosaur but a weak, nearly defenseless and quite unspecialized mammal which conquered Earth and will conquer the stars.

Well, those are some of the challenges you face - formidable, but we have a formidable group to attack them. And also, like the behaviorists that we are sometimes accused of being, your consultants have arranged for positive reinforcement upon completion of the task. The brilliant and sympathetic Deputy Surgeon General, General Mendez, has given priority to hearing what you have to say. He will be our wrap-up listener and speaker on Friday.

We will now hear from our other consultants.

BEHAVIORAL SCIENCES: 30 YEAR PERSPECTIVE

Vernon William, COL, MS

This is my Swan Song. After 30 years active service and 36 Total, I should be in a position to say what I think so I am going to try.

I liked the Behavioral Science meeting last September. We sat down in mixed groups and we talked, we argued, we compromised and we planned.

I didn't like the 70 meeting that Frank has described because we couldn't do any of those things.

I hope we can do the same thing this year with the problems we have confronting us because we are vitally concerned with many of those issues. In order to help set the stage for that, I'd like to describe where I think Social Work is coming from by addressing some gripes - Myths and Questions? First a Gripe.

I don't like the term Behavioral Scientist - I'm sorry we got stuck with it - I don't know a good definition for it but I am certain it doesn't necessarily translate "Mental Health" which is the definition used by some people in this room.

A social worker in the ACS program helping families adjust in their Army Communities with food stamps or supplying information about their next post that will help plan for a physically handicapped child is a behavioral scientist but with limited ties to this group. I wish we had a better name.

A myth - Social Work is losing all its spaces and is way over its authorized strength. Matter of fact, at the beginning of this year, we had 276 SW's on active duty. We had 254 authorized 68R spaces and 15 other approved assignments in MOS immaterial jobs. That's 269 authorized spaces or an overage of 7 people. I fully expect the 7 extra people will be gone by the end of the summer. On the other hand, Social Work in the Army as a career is very competitive with civilian programs and if more spaces are generated, we have people waiting in line to enter the Army. At our last bd in Jan, we had 31 applicants for 2 positions and we turned down some very well qualified people.

This leads me to how we distribute our assets. Social work is not necessarily a profession allied to medicine. In the Army however, it was for many years locked into that position. We (social workers) owe our existence in the Army to psychiatrists. That's how we got here and as far as I'm concerned that's where a large part of our assets will always be. Of the 276 social workers on active duty, about 65% work in the area of Mental Health - that is in direct relationship with psychiatirsts, psychologists,

and the rest of you in this audience. Another 25% work in relationship to other branches of medicine - Pediatricians, Internists, family practice, orthopedics, etc. The rest (10%) or less than 30 are in positions where they are doing other kinds of social work - that is not directly related to medicine.

I feel we are doing our part to support Mental Health programs and those people who are doing social work in non-psychiatric settings and other areas such as ACS, Research and Staff positions are not doing so at the expense of anybody in this room. In the days when social works only role was support of psychiatry, we had a maximum of 160 spaces. We have more than that today, and I would guess that our ratio of social workers to psychiatrists is also better today. As the Social Work Consultant, I stand ready and able to recommend an officer to fill any vacancy for a social worker that is generated by work units from any work area.

Finally I'd like to talk about separate Social Work Services in certain settings. Some people think we shouldn 't have them, some think we're going to lose them, but my message is they're here to stay. If the primary work arena is a community mental health activity or a psychiatry service. The social work role is negotiable, and that's one of the topics we'll discuss this week. If the primary work arena is the rest of the hospital, or an ACS setting and we're providing discharge planning for an elderly cancer patient or financial planning to an E-4 and his family, the role is not negotiable in this arena, this week. In order to properly meet as many needs as possible we need separate social work services in the medical center and large MEDDACs. As a matter of fact, the HSC reg, the Joint Commission on Accreditation and the American Hospital Association standards require a separate service in those settings.

In summary - In spite of the fact that my old age and my paranoia, may have been too evident during the past few minutes - the bottom line for our meeting here this week is to provide better care for all eligible personnel and social work stands ready to do its part in planning towards that end.

Thank you.

GUILD AND BOUNDARY ISSUES: Readdressed

As part of the introduction to the AMEDD Behavioral Sciences Seminar, LTC Hartzell discussed the topic of mental health professionals in the U. S. Army today. Unfortunately, a written summary of his remarks could not be made available for publication.

BARRY N. BLUM
CPT, MS
Editor

TASK GROUP I

PERSONNEL RESOURCE MANAGEMENT

Co-Chairmen:

Col Donald W. Morgan, Psychiatrist
Col Otto J. Schreiber, Psychiatrist

Members:

Col Phillip Hicks, Psychiatrist
Lt Col Jay Norton-Tappez, Psychiatrist
Maj William Sullivan, Psychiatrist
Lt Col Edgar J. Habeck, Social Worker
Maj James Tansor, Social Worker
Maj James Walsh, Social Worker
Lt Col Hubert A. Kelley, Social Worker
Cpt Edward T. Beaty, Psychologist
Cpt Franklin Brooks, Psychologist
Lt Col Edgar Cook, Psychiatrist
Cpt Edward O. Crandall, Psychologist
Maj Willie Patterson, Psychiatrist
Lt Col E. R. Worthington, Psychologist
Cpt Thomas Coleman, Psychologist
Cpt Lawrence Dilks, Psychologist
Lt Col Francis J. Fishburne, Psychologist

TASKS:

1. Designate needs for psychiatrists, social workers, psychologists, nurse clinicians and 91Gs and 91Fs Army-wide. How are requirements presently determined.

2. Recommend assignment of types of personnel at above facilities.

3. Propose plans to survive expected personnel shortages -- civilianization, regionalization, contracting, closing programs, assigning only social workers, etc.

4. Recommend assignment of specific personnel.

5. Propose changes to make isolated posts more attractive.

6. Is assignment of psychiatrists to a region with "circuit riders" a viable option? What are the advantages? Disadvantages?

RECOMMENDATIONS

I. TASK #1: Designate needs for psychiatrists, social workers, psychologists, nurse clinicians and 91Gs and 91Fs Army-wide. How are requirements presently determined.

A. Question or Task #1 is extremely far ranging and complex; however, the following recommendations on a general basis are made by the group:

1. MEDCENs with training programs should have top priority of resources in that they have the capability to generate and constantly renew the availability of trained professional personnel to provide service to the Division, Community Hospital (MEDDAC), and CMHA in that order.

2. The top priority for Division placement is to support our primary mission of combat support since this is why we exist in the first place. The second priority to Community Hospitals (MEDDAC) is to support the active duty soldier and his dependents, the latter being of utmost importance in sustaining the morale of the active duty soldier. The last priority of the CMHA does not mean to imply that support of the active duty soldier is not important. However, with scarce resources, the use of Division personnel supported by hospital personnel can accomplish the same objective.

3. Currently, requirements for mental health personnel at all facilities is determined via manpower surveys that use antiquated staffing guides. These guides desperately need to be updated to take into consideration the increasing number of administrative mandates imposed upon mental health personnel (audits, TAB, MCE, etc.) plus clinical requirements of supervision of paraprofessionals, consultation with other professionals, unit commanders, legal representatives, drug and alcohol programs, child protective councils, and rape crisis teams.

4. Once the availability of a psychiatrist becomes non-existent, the pretense of medical psychiatric care should be dropped and a clear definition of Social Work and/or Psychology Services presented to the Medical Commander so that he can seek other alternative services to fill the deficit.

5. The 91G assignment priorities should come under AMEDD control in order to fill the needs as they arise on a timely basis.

II. TASK #2: Recommend assignment of Types of personnel at above facilities.

A. Task #2 did not result in any firm recommendations due to the unique skills as well as areas of overlap among the various disciplines.

However, assignments might be based on operational model, i.e., as the needs are perceived at a particular facility to accomplish their particular mission, additional resources are requested through their respective consultants.

III. TASK #3: Propose plans to survive expected personnel shortages -- civilianization, regionalization, contracting, closing programs, assigning only social workers, etc.

A. Task #3 resulted in the following recommendations:

1. Unfilled HPSP slots up to 10 be diverted to find clinical psychologists for civilian training programs.

IV. TASK #4: Recommend assignment of specific personnel.

A. Task #4 resulted in the following recommendation;

1. Managers (consultants) should know their personnel personally and keep records of their career progression. In this manner they could tailor assignments and match job requirements to individual's needs and wants. (Ex: Jay Norton at Fort Huachuca).

V. TASK #5; Propose changes to make isolated posts more attractive.

A. Task #5 resulted in the following recommendation:

1. Facetiously speaking, "isolated posts" could be eliminated or labelled "career advancement tours". More seriously, the following incentives should be considered:

a. Choice of next assignment with an absolute guarantee
b. Additional TDY
c. Additional pay incentives
d. Maximizing resources and personnel
e. Shorter tours

VI. TASK #6: Is assignment of psychiatrists to a region with "circuit riders" a viable option? What are the advantages? Disadvantages?

A. Task #6 resulted in the following recommendations:

1. Possible concept: However, must be free from other responsibilities, not an additional duty; should be assigned to the Office of the Chief of the Regional MEDCENs and be allowed to home base at the MEDCENs.

2. Advantages: Would provide Medical Psychiatric Services at facilities that otherwise would have none.

3. Disadvantages: Early burn out; travel problems due to distance, weather, fuel shortages.

4. Would require a Senior individual due to intermittent contacts.

VII. Additional recommendation:

1. The re-establishment of a full-time social work consultant.

TASK GROUP 2: TRAINING ISSUES

TASK GROUP LEADER: David T. Armitage, M.D., J.D., LTC, MC, Asst Chief, Dept of Psychiatry & Neurology and Director of training & Research, DDEAMC, Fort Gordon, Georgia

TASK GROUP MEMBERS:
COL Nicholas L. Rock, Psychiatry
LTC T. J. Chamberlain, Psychiatry
LTC Lucien B. Fleurant, Psychiatry
MAJ Emmanuel Cassimatis, Psychiatry
MAJ Tom Lawson, Social Work (Author of Appendix C)
MAJ James E. McCarroll, Psychology
MAJ Ray V. Smith, Social Work
MAJ Ed VanVranken, Social Work
CPT Philip Appel, Social Work (Author of Appendix B)
CPT (P) Jack Bentham, Psychology
CPT Don Headley, Psychology
CPT Thomas K. Sims, Psychology
CPT Kerry W. Wyant, Psychology

OBJECTIVE OF THE TASK GROUP: The objective of the Task Group on Training Issues was to examine training in the mental health fields in the AMEDD as to current problems requirements, needed modifications, and to render appropriate recommendations in these areas.

FINDINGS:

ISSUE #1: STAFFING OF TRAINING PROGRAMS (ADEQUACY OF NUMBERS AND CALIBER).

RECOMMENDATIONS:

a. The number of psychiatric staff must be increased for psychiatric training programs.

b. Recruitment and retention of appropriate social work officers in support of psychiatric training programs should be improved by increasing military sponsored training opportunities for social workers at the doctorate level,

specifically for faculty involved in training programs, and by adding a skill identifier to the MOS to enable easy identification on a screening basis of potential staff members with unique skills useful in training programs.

c. Career planning is essential in both the recruiting and retention of appropriate faculty.

ISSUE #2: TRAINEES (QUALITY AND QUANTITY).

RECOMMENDATIONS:

a. Quality of trainees must be maintained even at the expense of quantity.

b. Number and location of training programs should be increased in order to attract a variety of trainees.

c. A policy and system must be established and developed to appropriately assign and utilize people of advanced military rank who are novices in their professional life because of transfer of branch or other considerations.

d. Ten to twelve Health Professions Scholarship Program spaces should be created and allocated to Psychology as a means of recruiting qualified psychology graduate students into the Army.

ISSUE #3: TRAINING WITHIN THE MILITARY SETTING (SHOULD IT OCCUR?)

RECOMMENDATION:

Training must be maintained in the military setting because:

(1) There is a need for dedicated personnel identified with the military system.

(2) Retention of people trained within the military is much higher.

(3) The military has unique features important to practice within it (see Appendix A).

ISSUE #4: CORE CURRICULUM.

RECOMMENDATION:

The issue of core curriculum is not settled at a national level in the various professional groups. Consequently, it is recommended that:

a. Establishment of curriculum for training programs should be done on an individual basis until such time as national groups establish firm priorities for core curriculum.

b. In order for curriculum (and other pertinent data) to be exchanged, there must be an opportunity for coordination of curriculum material. This can best be done by a meeting of the various training directors on an annual basis.

ISSUE #5: INFORMATION SHARING.

RECOMMENDATION:

To prevent duplication of training efforts and to prevent inappropriate establishment of training activities, coordination is required. It is recommended that a mental health training bulletin be established and printed on an "as needed" basis, no less than once per year with wide dissemination. This bulletin should be produced by the consultants to the Surgeon General with input from training directors.

ISSUE #6: CURRENT PROGRAMS (APPROPRIATENESS OF LOCATION AND NUMBER OF TRAINEES).

RECOMMENDATION:

There is no recommendation for discontinuing or modifying the location of current programs. However, the difficulties identified in the current program, such as attractiveness of location, must be faced directly and countered with appropriate ingenuity.

ISSUE #7: NEW TRAINING PROGRAMS.

RECOMMENDATION:

a. A training program in psychiatry should be considered for Madigan Army Medical Center.

b. Specialized postdoctorate fellowships should be established for psychology in community health, neuropsychology, and child psychology.

c. A "third year" training program for social workers should be established in the areas of "combat social work" and "psychiatric social work."

d. Sufficient numbers of slots for training in social work at the doctoral level should be established with the specific intent of utilizing these graduates in military psychiatric/psychological/social work training programs.

e. Consideration should be given to the establishment of coordinated training in family therapy for psychiatry, psychology and social work. The components of this training are currently available, but there is no coordination nor formal authorization involved at the present time.

ISSUE #8: UNIQUE ASPECTS OF THE ARMY AS RELATED TO TRAINING.

RECOMMENDATION:

The Task Force identified 11 significant aspects of the military that could be considered unique and of special interest to individuals practicing within that setting that should be addressed in all training programs. (See Appendix A).

ISSUE #9: RELATIONSHIPS BETWEEN THE VARIOUS PROFESSIONS INVOLVED IN TRAINING PROGRAMS (KEY INVOLVEMENT).

RECOMMENDATION:

a. Neurology should be part of a Department of Psychiatry and Neurology, especially where there are psychiatric or neurologic training programs.

b. All training must occur within the context of professional and Army policy.

c. The professions concerned must continue to work actively at role definition in terms of activity and mission following training and that this be reflected in the training program development.

ISSUE #10: RESOURCES.

RECOMMENDATION:

a. Financial, space, and staff resources involved in training programs must be under the operational control of the training director for required key personnel. Example: Psychiatric Social Work Services must be available to a psychiatric training program. A program cannot rely merely on the good will of another separate service chief to provide this resource. The resource must be within the Department of Psycniatry and Neurology (see above recommendation concerning doctoral training and social work).

b. Programs can be co-located (example: psychiatry and psychology), if training cases are adequate so as to maximize the utilization of important faculty resources.

c. Internships in psychology should also be made available at nonconcurrent training sites with the purpose of spreading out the service delivery aspects of training to other military facilities.

ISSUE #11: COMMUNITY MENTAL HEALTH ACTIVITIES AS TRAINING SITES.

RECOMMENDATION:

a. The incredible lack of uniformity in staff, mission, and performance among the various CMHA's prevents a specific recommendation as far as utilizing CMHA's as training sites. It is recommended that the CMHA be more specifically defined within policy.

b. There must be training in a military milieu having significant troop strength that is mission oriented. It is recommended that a study be done of the present status of CMHA's, and that other options be considered for meeting this goal.

ISSUE #12: TRAINING OF 91G's.

RECOMMENDATION:

The responsible authority at the Academy of Health Sciences should gather specific information from the field as to experience with the caliber and background training provided to 91G in respect to their utilization.

ISSUE #13: POLICY.

RECOMMENDATION:

a. Policy regarding functions and utilization of the various mental health disciplines in the AMEDD's must be firmly established by the appropriate and clearly delineated lines of authority and responsibility via AR 40-216. It is strongly recommended that policy be based upon input from the field before it is written and implemented.

b. Policy guidelines should be the first source consulted in addition to the respective professional accrediting requirements when developing training programs in the military. This will answer the question, "Training for what?"

SPECIAL ISSUE: SOCIAL WORKERS AS AMEDD MENTAL HEALTH PERSONNEL (APPENDIX B; ELABORATED UPON IN APPENDIX C).

RECOMMENDATION:

a. Because social work provides services and resources for areas other than mental health, social work must define its roles as related to the various areas in which it works.

b. Social work should have a senior professional named who will have the authority and the necessary time to assist the TSG Consultant Division in personnel management and program development as it relates to developing social work officers for training programs within the AMEDD.

SPECIAL ISSUE: PSYCHOLOGY.

RECOMMENDATION:

a. Psychologists should be considered for special professional pay.

b. Career programs should be developed that take into account the particular area of expertise of psychologists in the Army such that there is an increase in senior rank and leadership within the profession of psychology.

SPECIAL ISSUE: MUTUALITY AND COMPETITION BETWEEN MENTAL HEALTH PROFESSIONS AS THEY INTERFACE WITH TRAINING.

RECOMMENDATION:

a. Roles must be defined in accordance with policy as noted above.

b. It is most important that the mental health discipline in the AMEDD coordinate and complement their functioning to serve the needs of the Army and to prevent dilution of mental health service quality which is prone to occur when these functions are not under the professional and technical supervision of the AMEDD.

SPECIAL ISSUE: RELATIONSHIP BETWEEN TRAINING CENTERS AND USUHS.

RECOMMENDATION:

a. Upon nomination by the director of medical education or the department chief and forwarded to the Chief of Psychiatry at the USUHS, appropriate staff should receive clinical appointments to the medical school faculty.

b. Training faculty from the established programs in the medical centers can be used as resources for providing didactic input to the medical school itself, based upon unique expertise.

c. The medical center training programs can be used as field clerkship sites for 3d and 4th year medical students to provide them an educational experience, a sense that military medicine is a viable and contributing entity in the United States Army, and exposure to a variety of training/service settings in which military medicine is currently practiced.

APPENDIX A - UNIQUE ASPECTS OF THE ARMY RELATED TO TRAINING

1. The United States Army has an overt formal organization with clearly defined roles of leadership and followership.

2. There is frequent movement of families and personnel with all issues attendant thereto.

3. The Army has a combat mission.

4. With its codes, regulations, dress, and training, the Army aims for a degree of uniformity among its members.

5. Given the mission, uniformity, frequent movement and other special aspects noted in 4, above, there may be professional/personal/group mores and values which at times conflict.

6. There is a world-wide distribution of military resources requiring adjustment to foreign cultures which, combined with frequent movement, creates additional adaptive stress upon its members and dependents.

7. Professionals in the Army have the ability to move up rapidly in responsibility and authority compared to their civilian counterparts.

8. The population served by professionals in the Army is unique in the sense that there is much prescreening of personnel prior to admission to the Army and the population is generally healthier. In addition, the average age of the currently served population is younger than the average age seen in civilian practice.

9. Treatment within the military can be dispositional in nature (which is not critical of the treatment but serves to describe its nature and function). There is no long-term patient management for other than retired personnel.

10. Professionals may change jobs without necessarily losing rank or pay. In contradistinction, however, they may move up in responsibility without being concurrently rewarded with increase in rank or pay.

11. There is a great need for administrative skills in all military professionals.

APPENDIX B

SOCIAL WORK

SECTION I

GENERAL

1. PURPOSE. This appendix is in response to the request made by Task Group 2 (Training Issues) at the 1979 AMEDD Behavioral Science Seminar at Fitzsimons Army Medical Center, Denver, Colorado. The request was for Social Work to be defined so that other disciplines would know how to interface and work with social workers as members of the Behavioral Science Team.

2. DEFINITION. Social work seeks to enhance the psycho-social functioning of individuals, singly and in groups, by activities focused upon their psycho-social relationships which constitute the interaction between man and his environment. These activities can be grouped into three functions: restoration of impaired capacity; provisions of individual and social resources; and prevention of psycho-social dysfunction.

SECTION II

SOCIAL WORK PRACTICE

3. GENERAL STATEMENT. Ultimately social work practice is determined by the setting in which the social worker is functioning. Different skills are brought to bear in different settings for different human needs and problems. In the Army, social workers can be found in a variety of different settings including Division Mental Hygiene Consultation Services, Community Mental Health Activities, Social Work Services, Alcohol and Drug Abuse programs, corrections, research, etc. Each one of these settings may involve utilizing a different knowledge base and skills to meet the needs and problems of service members and their dependents. However there is a common core of knowledge generic to social work, and that being: 1) Psycho-social functioning of individuals; 2) Social welfare programs and policies; 3) Scientific method; 4) Goals and values of social work; 5) Theory and principles of practice.

4. GOALS. There are three general goals in social work practice:

a. Curative, ameliorative (treatment orientation).

1) To assist individuals, families or other small groups in coping with their problems in psycho-social functioning.

2) To assist social organizations (including military units of all sizes up to a division), neighborhoods, or communities in coping with their problems that are related to the problems of their members or residents.

2) To rehabilitate people who are defective in their psycho-social functioning.

b. Preventive (action orientation)

1) To identify potential areas of problems and to strengthen existing healthy forces (primary prevention).

2) To detect early symptoms of problems and to intervene at this stage to halt their spread (secondary prevention).

3) To limit the manifestations of problems through anticipatory action and rehabilitation (tertiary prevention).

c. Promotional - enhancing (developmental orientation).

1) To meet needs and enhance the psycho-social functioning of individuals, families, or other small groups to move toward existential fulfillment through psycho-social participation.

2) To enhance the maximum potential of social organizations (including military units...), neighborhoods and communities to insure the existential fulfillment and maximum self-realization of people through psycho-social participation.

5. MAJOR FUNCTIONS. There are seven major functions in social work practice.

a. Help people enhance and more effectively utilize their own problem-sovling and coping capacities.

b. Establish initial linkages between people and resource systems.

c. Facilitate interaction and modify and build new relationships between people and societal resource systems.

d. Facilitate interaction and modify and build relationships between people within resource systems.

e. Contribute to the development and modification of social policy.

f. Dispense material resources.

g. Serve as facilitators of psycho-social modification.

6. PRIMARY METHODS. In social work a method is an orderly systematic mode of procedure. In a particular setting and job assignment the social worker may use one or several methods. Below is a partial list of the primary methods.

a. Administration
b. Case work
c. Community organization
d. Consultation
e. Education
f. Group work
g. Planning
h. Program development
i. Psychotherapy
j. Research
k. Supervision

SECTION III

CLINICAL SOCIAL WORK

7. General Statement. In the Army approximately 60% of all social workers are working in mental health related settings in support of psychiatry. As these settings provide interface and collaborative work with psychiatrists and clinical psychologists it becomes important to define clinical social work for the following reasons:

a. Bringing clarity to the areas among the three professions which seem to overlap.

b. The fact that states are now licensing and certifying social workers to practice in prescribed ways.

c. To familiarize the other members of Army Medical Department with the realm and domain of social work.

d. That clinical social work occurs in hospital settings in support of non-psychiatric services and departments as well.

e. That the American Hospital Association has published a manual describing 'The Essentials of Social Work Programs in Hospitals" (entitled the same, AHA 1971).

f. That the Joint Commission on Accreditation of Hospitals in its accreditation manual for hospitals specifies the minimum need for social work services and in what manner (Accreditation manual for hospitals, pages 169-172, 1979 edition published by JCAH).

8. National Association of Social Workers definition of clinical practice... "Clinical practice is that aspect of social work which is carried out in a one-to-one or one-to-group situation by a practitioner exercising general skills in a self directed manner. It encompasses assessment, diagnosis and treatment of problems of intrapsychic and interpersonal conflicts and their

effects on the self and others. It involves utilizing community resources and providing help in coping with illness, both medical and psychiatric. It develops psychological readiness to function more effectively in relation to family, peers, associates and the community and in relation to employment, education, and other goals. Clinical practice involves the knowledge and treatment of defineable psycho-pathology through psycho-social and psycho-therapeutic skills in which the practitioner is both qualified and competent." ("working papers of the NASW cabinet of practice and knowledge: Specializations", May 1974.)

9. State of California Definition of Clinical Social Work Practices. "The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior is directed at helping people to achieve more adequate, satisfying and productive social adjustments. The application of social work principles and methods includes, but is not restricted to counseling and using applied psychotherapy of a non-medical nature with individuals, families, groups, providing information and referral services, providing or arranging for the provisions of social services, explaining and interpreting the psycho-social aspects in the situations of individuals, families or groups, helping communities to organize, to provide or improve social and health services and doing research related to social work". (taken from laws relating to licensed clinical social workers, Chapter 17, Division 3, Business and Professions Code, Chapter 17, Article 4, Paragraph 9049.)

10. National Federation of Societies for Clinical Social Work Definition of Clinical Social Work in Hospital Settings: "1.2 The term "clinical social work practice in health care" refers to, but is not limited to one or more of the following: A. The evaluation and treatment of disability resulting from the emotional stress due to physical illness.

B. Assisting medical and other health care staff in planning for appropriate treatment of patients based on the clinical social worker's awareness of family dysfunction that interfers with appropriate use of community resources.

C. Assisting medical and other health care staff in arranging for alternative medical treatment based on the clinical social worker's knowledge of community resources.

D. Evaluation and treatment of stress resulting from family dysfunction as well as social, economic and community dysfunctions that impinge on patients ability to recover from physical illness.

E. Helping patients suffering from chronic or terminal illness to function within the limitation of that illness by the use of psychotherapeutic modalities.

F. Arranging discharge planning for patients based on the knowledge of, and skill in utilizaing community resources.

G. Placement of medical or psychiatric patients in appropriate level of out of home care. Assisting the patient and his family in adapting to that treatment plan and monitoring his care throughout placement and making replacements when necessary.

H. Skill in helping patients adapt to demands of daily living in recovering from illness.

I. Evaluation and treatment of emotional disorders and mental illness.

J. Skill in helping persons with conscious and unconscious conflicts in relation to the total emotional and social environment in which they must function, through professional help which includes but is not limited to individual, marital, family and group psychotherapy and counseling.

K. Program development services toward upgrading of patient care rehabilitation including training of staff in human growth and development, and the designing of programs to emphasize the emotional and social components of illness and disease" ("General standards for health care providers in clinical social work in hospital settings" January 1975).

APPENDIX C

Social Work Training Proposals

(1)

1. Identify ROTC graduates who are going for civilian MSW training and if possible get them into military field placements as part of their civilian training. May also be able to utilize them in summers also. Thus, will have new MSW coming into the Army with 2 years identification and knowledge of military systems and programs.

2. Develop a 1 year "Combat Social Work Internship". Directed toward company grade social work between 3 and 7 years service. The curriculum would be partial didactic in crisis intervention, command consultation TSD, etc. The practicum would be a minimum of 6 months in a combat division under a mentor of proven capability, program approximately 1 year in length. Possibility of assignment for practicum to reforger.

3. Develop a 1 year "Clinical Internship" that is primarily oriented toward developing clinical and therapeutic skills in working with individuals, families and groups. Probable locations for such programs is with psychiatric residences and psychology internships at major MEDDACS or Med Cens for availability of staff.

(2)

4. Continue the Family Program at WRAMC with support from sister disciplines.

5. Develop slots in the Psychiatric Training Program that are in addition to the Social Work Service Slots. These slots would be faculty positions in the Residency Programs where social workers could contribute their expertise to the training of psychiatrists. These would be additional slots for social work and also should be validated Doctoral positions. Thus an overall increase in slots and in Doctoral slots.

6. Develop a way to identify individuals on OER and similar documents as well as a brief held by the consultant that would list specialty skill qualifications and abilities. The completion of the above mentioned programs, drug and alcohol, ADS or community experience should be recognized and utilized [illegible]. [illegible] assist in "best assignments" but assignments must not be "tied" to identifiers.

(3)

7. Adopt a policy that [illegible] Army officers who have obtained a MSW. The MOS of [illegible] this [illegible] with rank above Captain. This [illegible] be adopted [illegible]

(Cont)

that enter with a higher rank automatically become (a) supervisors of MSW's who may have many more years of experience, (b) Chiefs of Services with no or little background and the possibility exists for many mistakes due to lack of experience.

8. It is apparent that all of the above programs and proposals that deal with training issues and skill progression are most important to the AMEDD mission. These programs cannot be effectively developed and implemented under the current situation of a 1/5 time consultant. It is, therefore, recommended that emphasis should be placed on reinstating the Social Work Consultant at OTSG as a full time requirement.

9. Unique SW contributions to the training of psychiatrists and psychologists.

   (a) The whole dimension of child and family problems, treatment and systems.

   (b) A systems approach to military communities (units and posts) - Assessment, Development and Implementation of Programs to meet the needs of any given organization.

   (c) Knowledge of and liaison with community resources.

   (d) Provision of specific services, eg. adoption, child abuse, foster care, handicapped, etc.

   (e) Knowledge of and programs for military offenders.

MOST IMPORTANT

   (f) Unit consultation and promotion of mental health within combat units.

I. Task Group 3

Title: Revision of AR 40-216 "Neuropsychiatry"
Leader: K. Eric Nelson
C, Dept of Psychiatry and Neurology
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II. Members of Task Force:

COL Joseph Lloyd
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LTC Robert Kazuki
LTC Donald Myles
LTC John McCormack
LTC Daniel Anderson
LTC Louis Carmona
MAJ Bob Newberry
MAJ Peter Klugman
MAJ Paul Ellsworth
MAJ Robert Sands
MAJ T. B. Jeffrey
MAJ W. A. Waitz
CPT Nathan Bender
1LT Paul Arronbee

III. Background:

AR 40-216 regulates the principles and operations [illegible] have been designated "Neuropsychiatry" [illegible] Department. Now in its 20th year without revision, the [illegible] outlined in 1959 summarize the accumulated experience of [illegible] major armed engagement during this century [illegible] application in the Vietnam Conflict.

The concepts of [illegible] adapted from the public health model [illegible] service delivery principles of immediacy, [illegible] casualties, with [illegible] simple interventions, [illegible] evacuations through [illegible] under appropriate [illegible] ing the [illegible]

Despite [illegible] two decades [illegible] service delivery, [illegible] and updating [illegible]

no longer adequately defines the scope of the program. In the civilian arena, an adaptation of the principles of military neuropsychiatry formed a base of the 1963 Community Mental Health Act, which, with implementation and subsequent modification has had what has been termed a "revolutionary" impact on the organization and delivery of mental health programs in the United States. This in turn has led to development of more and different manpower resources to support programs with redefinition of traditional professional interests, expertise, and alignments. Within the Army, both an impact from these developments has occurred, and also several new programs have been developed to provide primary preventive services, e.g., the Army Community Service program in 1966, the Drug and Alcohol Prevention and Control program in 1971; the Child Advocacy and the Organization Effectiveness programs in 1976. A major reorganization of the Army as a system was accomplished in 1973, and at the same time the shift from a conscripted to an all-volunteer force. Within the professional disciplines providing Army "neuropsychiatric" services, the role of the psychiatric mental health nurse specialist has been evolving, social work has been established as a separate service, the psychologist has been added to the TOE of divisional units, occupational therapists have developed new skills and interests, the role of the behavioral science technician has been refined, the Family Practice has been developed as a new medical specialty.

To incorporate changes then current, an attempt was made to staff a revised regulation in 1969. This was unsuccessful, primarily due to disagreement over operational issues amongst the participating professional disciplines. Since that time the program has been operated more on the spirit of the regulation than on written guidelines.

IV. Objectives:

1. To present a draft of a revised AR 40-216 regulation for group work to finalize and ready for staffing at DA level.

a. To define roles of mental health professionals from each participating discipline at all operational levels in combat, CONUS and overseas garrisons.

b. To define roles of mental health paraprofessionals at all operational levels.

c. To consider credentialling and continuing education requirements for mental health workers.

d. To consider boundary issues among the specialties - psychotherapy, assessment, forensic evaluations, etc.

V. Conclusions (See Appendix A for revised AR 40-216):

1. That a line-by-line revision of the draft regulation as presented

and discussed at the 19[illegible] Science Conference be completed by each mental [illegible] representative - psychiatry, psychology, social work, [illegible] occupational therapy.

2. That a compiled [illegible] be circulated to each member of the task [illegible] for final review, decision, and justification of [illegible].

3. Based on 2 above, [illegible] be developed by Chief, Department of Psychiatry and [illegible] Social Work Services, Chief, Psychology Service, and [illegible], Eisenhower Army Medical Center, working as a small [illegible] to CHPC for staffing by 30 Sep 1979.

a. That a portion [illegible] be included in the final draft.

MEDICAL DEPARTMENT
ARMY MENTAL HEALTH PROGRAM

This is a complete revision. This regulation provides policy and guidance to commanders with regard to problems of mental health and psychosocial effectiveness as they affect the military in combat siutations within a theater of operations and in support units and training bases throughout the Army.

APPENDIX A

SECTION I
GENERAL

1. PURPOSE: To describe basic Department of the Army concepts, policies, and practices regarding the AMEDD Program to maintain mental health and psychosocial effectiveness.

2. OBJECTIVES: To aid command to conserve the manpower of the Army and to maintain it at the highest possible peak of efficiency through the application of sound psychiatric and behavioral science principles and services.

3. APPLICABILITY: This regulation applies to all personnel entitled to care in Army medical treatment facilities (MTF). It does not apply to members of the Army National Guard or US Army Reserve who are not on active duty.

4. CONCEPTS: Through experience gained in the two World Wars, the Korean and Vietnam conflicts, and during peacetime periods of training and mobilization, a group of effective principles have evolved and will be utilized in the prevention, treatment, and management of psychiatric and psychosocial disorders.

a. Primary emphasis will be placed on preventive programs.

(1) Major attention will be directed toward conditions threatening to the mental health and psychosocial effectiveness of individuals in the military community with corrective professional action or advice provided as possible.

(2) Prompt evaluation, rapid diagnosis, and early treatment with simple methods in the duty environment are important in minimizing morbidity and insuring early resumption of effective performance.

b. In both combat and training situations, treatment of stress reactions and psychiatric casualties will be instituted early, as proximate to the person's duty unit as practicable, in a military rather than a hospital atmosphere, with an attitude of expectancy of return to duty. Evaluation and treatment should be initiated at the Battalion Aid Station or other forward medical echelon having initial contact with the casualty. Early return to duty is the desired objective and is intrinsically therapeutic for the majority. The medical officer must accept full responsibility for providing effective treatment as briefly and simply as possible and for timely discharge to duty. Psychiatric casualties other than those treated successfully at the initial medical echelon will be channeled to the division mental health team or, when appropriate, to the psychiatric treatment facility in direct support of the combat unit in a continuous effort to avoid loss of manpower. Psychiatric referrals from combat support units will be made to the nearest MTF.

c. In both combat and non-combat situations, the evaluation, treatment, and disposition of non-psychotic psychiatric casualties will, except in unusual circumstances, be accomplished on an outpatient status. Retention of this group on duty status usually facilitates treatment and reduces non-effectiveness.

d. Necessary evacuation of psychiatric casualties will be centralized and monitored through a specified hierarchy of medical treatment facilities so as to maximize return to duty at each level.

e. In both combat and non-combat situations, direct technical

communication and liaison among mental health staff to include the regional consultants in psychiatry, psychology and social work, the division psychiatrist, social worker and psychologist, the team OM medical detachment (psychiatric) and the hospital-based psychiatrist will be maintained.

f. The overall effectiveness of the program is dependent on the proper distribution, assignment, and utilization of qualified personnel. It is essential that mental health staff be carefully selected, trained, assigned, and utilized in accord with their capabilities in order to assure mission effectiveness.

g. The delivery of technical services by mental health personnel will be consistent with professional and paraprofessional competencies as determined by their education, training and experience and validated by appropriate credentialing procedures designated by the Commander.

5. EXPLANATION OF TERMS:

a. Army Mental Health Program: The overall organization of AMEDD personnel, programs and services aimed at the promotion of mental health, psychological effectivenss and optimal social functioning and the prevention, minimization, and effective handling of mental and emotional disorders of active duty personnel.

b. Mental Health Team: A coordinated group of mental health professionals with complementary and supplementary skills. It may include the psychiatrist, neurologist, social worker, clinical psychologist, psychiatric nurse, and occupational therapist. The professional team may be supplemented with the 91G behavioral science specialist, the 91F psychiatric ward specialist, and the 91L occupational therapy specialist.

c. Mental Health Activity: An organized local program of Army community mental health services including preventive and educational measures, consultation and outpatient evaluation, treatment and disposition, together with its operating staff.

6. RESPONSIBILITES:

a. The Surgeon General has general staff responsibility for the Army Mental Health Program and will support it with resources and technical assistance in conJunction with other activities relating to the provision of health care to service members and their families.

b. Interface and coordination will be established as appropriate with:

(1) Those personnel effectiveness, organizational effectiveness, and human development programs under supervision of Deputy Chief of Staff for Personnel. Particular attention will be paid to the Army Alcohol and Drug Abuse Prevention and Control Program and the Army Child Advocacy Program.

(2) Those welfare programs and services under supervision of The Adjutant General.

(3) Those programs relating to the morale of service members and their families under supervision of the Chief of Chaplains.

c. Staff mental health professionals at all levels will:

(1) Provide the highest standard of professional service in the prevention, diagnosis, and treatment of mental, emotional, and personality disorders and in the evaluation and disposition of such involved military personnel.

(2) Advise the Commander in mental health matters

pertaining to the morale and psychological effectiveness of troops. The majority of factors which affect the mental health and morale of troops fall within the responsibility of command, e.g., provision of proper leadership, training, assignment, incentive, motivation, rest, recreation, and elimination of the unsuitable, inept, and unfit. In order to be of optimal assistance, staff mental health professionals will:

(a) Maintain liaison with staff agencies and command at all levels as well as individual service members in order to elicit pertinent information relative to the mental health, psychological effectiveness, and social functioning of troops.

(b) Conduct appropriate studies on matters having mental health implications, e.g., [illegible] and group cohesiveness.

(c) Maintain adequate statistical data on the incidence and prevalence of psychiatric disorders and adjustment problems, and the effectiveness of remedial programs.

(d) Advise on the number and type of potential psychiatric casualties.

(e) Provide technical advice regarding the formulation and promulgation of professional and administrative policies pertinent to the selection, utilization, and disposition of military personnel.

(f) Recommend [illegible] to alleviate or remove situational factors [illegible] conditions [illegible].

(3) Devise and [illegible] mental health which:

(a) Orients and educates [illegible] of preventive medicine which [illegible].

(b) Provides for the [illegible] of psychiatric and adjustment difficulties [illegible] institution of corrective [illegible] recommendation for discharge.

(c) Recommends [illegible] psychosocial policies.

(4) Implement [illegible] program that is [illegible] for the sorting and treatment of [illegible] consonance with AMEDD [illegible].

(5) Conduct [illegible] the interest of current function and [illegible].

(6) In the interest of [illegible] strength, maintain for the [illegible] commanders, personnel officers, [illegible] officers, troop information and [illegible] effectiveness staff officers, [illegible] officers, [illegible] superiors and associates [illegible].

(7) Maintain [illegible] AR's, good [illegible] standards.

7. ELIGIBILITY. [illegible] Mental Health Services will be [illegible] AR 40-3.

SECTION II
Mental Health Programs in Operational Units

8. MENTAL HEALTH TEAM, COMBAT DIVISION: The Combat Division TO&E includes, within the medical battalion, a division psychiatrist, social work officer, clinical psychologist and 6 to 8 91G behavioral science specialists. These personnel will be organized to comprise the mental health team. The mental health team will:
a. Discharge the staff mental health professional responsibilities enumerated in paragraph 6 (c) above.
b. In combat provide the reception, evaluation, triage, management, and rehabilitation of psychiatric casualties at appropriate levels within the division and in accordance with the concepts in paragraph 4 above.
c. In garrison or reserve overseas operate a Mental Health Activity to include ongoing training of the Mental Health Team personnel, provision for outpatient evaluation, examination and treatment, recommendations regarding referred personnel, and consultation with command. The team should take any and all measures to promote the preventive mental health program of the division. Ongoing training directed toward preparation for combat will receive special attention.
d. When the division is garrisoned on a post or station with a Mental Health Activity established by the local MEDDAC, the Division Mental Health Team may co-locate its Mental Health Activity with that of the MEDDAC and integrate professional functions so that the Division Team augments the MEDDAC Team. In this situation the Division Team will continue to concentrate its professional time and attention primarily on division personnel and problems, and will in particular continue to serve for the division those staff responsibilities mentioned in paragraph 8(a) and enumerated in paragraph 6(c) above. The Division Team will maintain its organizational integrity and must be prepared to move in whole or in part with the division or its elements on training or other missions.
e. The active, ongoing promulgation and operation of the division mental health program is not only a continuing daily necessity in terms of staff responsibility and casualty handling, but is in itself essential training and familiarization for the mental health team in preparation for combat. The division mental health program and the division training program and mission support schedules should complement and support each other wherever possible.
9. DIVISION PSYCHIATRIST:
a. The Division Psychiatrist is assigned to the division medical battalion and in addition is on the staff of the Division Surgeon. He has primary staff responsibility for medical supervision of the division mental health program, psychiatric care of the division, and psychiatric consultation. He is in intermediate technical relationship between the division mental health team and the regional, medical command, or DA psychiatric consultant. Whether the division is in garrison, in field training, or engaged in combat, the problems encountered require the same basic professional concepts and staff functions noted in Section I above.
b. The Division Psychiatrist will:

(1) Carry out all applicable staff responsibilities enumerated in paragraph 6 (c).

(2) Serve as professional staff consultant for the division medical services on psychiatric matters.

(3) Participate directly in patient care and assume resonsibility for the medical supervision of those caring for psychiatric patients.

10. DIVISION SOCIAL WORK OFFICER:

a. The Division Social Work Officer is assigned to the division medical battalion and in addition is on the staff of the Division Surgeon as the social work consultant to the division.

b. The Division Social Work Officer will:

(1) Carry out the applicable staff resposibilities enumerated in paragraph 6 (c).

(2) With the Division Psychologist supervise the technical training and work of the enlisted specialists in the mental health team.

(3) Perform liaison and staff advisory duties as necessary for the promulgation and implementation of the division mental health program.

(4) Provide social systems assessment of the mental health of the division.

(5) Provide counselling and rehabilitation services in accordance with professional training and expertise.

(6) Maintain technical communications with consultants at all levels.

11. DIVISION PSYCHOLOGIST:

a. The Division Psychologist is assigned to the division medical battalion and in addition is on the staff of the Division Surgeon as the psychology consultant to the division.

b. The Division Psychologist will:

(1) Carry out all applicable staff responsibilities enumerated in paragraph 6 (c).

(2) Actively participate in command consultation within the division.

(3) Participate directly in patient care and the technical supervision and training of those enlisted specialists engaged in providing psychological assessment services in the mental health team.

(4) Conduct behavioral science research in support of the division mental health program.

(5) Provide psychological assessment as indicated.

(6) Maintain technical communications with consultants at all levels.

c. Typical command consultation duties may include but are not limited to:

(1) Consultation on the prevention and management of combat stress.

(2) Training of personnel in methods of dealing with combat stress.

(3) Participation in unit and individual preparation for combat operations.

(4) Assistance in officer and NCO leadership training.

(5) Assistance in SSI reclassification and in personnel management recommendations.

(6) Provision of liaison and consultation to division

(1) Carry out all applicable staff responsibilities enumerated in paragraph 6 (c).

(2) Serve as professional staff consultant to the division medical services on psychiatric matters.

(3) Participate directly in patient care and assume responsibility for the medical supervision of those cases for psychiatric patients.

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(2) With the Division Psychologist supervise the technical training and work of the enlisted specialists in the mental health team.

(3) Perform liaison and staff advisory duties as necessary for the promulgation and implementation of the division mental health program.

(4) Provide social systems assessment of the mental health of the division.

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(2) Training of personnel in methods of dealing with combat stress.

(3) Participation in unit and individual preparation for combat operations.

(4) Assistance in officer and NCO leadership training.

(5) Assistance in SSI reclassification and in personnel managment recommendations.

(6) Provision of liaison and consultation to division

organizational effectiveness programs.

12. TEAM OM, MEDICAL DETACHMENT, PSYCHIATRIC:
a. The Team OM is a deployable T O & E unit staffed and organized to function as a complete neuropsychiatric treatment center in a theater of operations. It is designed to be attached to an evacuation hospital or other medical unit for logistical support.
b. The team OM will operate in consonance with the concepts and responsibilities described in Section I of this regulation.
c. The team OM may operate as a single large neuropsychiatric treatment center or may be apportioned into a 25 bed neuropsychiatric ward service with as many as three separate mental health consultation teams operating at satellite locations. Staffing is similar to that described in paragraph 8 though quantitatively augmented and with the addition of psychiatric nursing and occupational therapy personnel to meet the expanded second echelon treatment mission.
d. The Team OM will operate in direct support of the combat situation, and will receive, treat, and make disposition on all neuropsychiatric casualties not handled successfully in divisions or other forward units.
e. The Team OM will operate a preventive and therapeutic mental health program in the base areas in which it is located. It will provide forensic services to the theater confinement facility if such is established.
f. The team OM will usually serve as the second echelon evaluation center in the specified hierarchy for out-of-theater evacuations. Every effort will be made at all levels to minimize neuropsychiatric morbidity and psychosocial dysfunction and to return military members to duty in order to maximize the use of manpower and avoid crippling individual failures.
g. Neuropsychiatric medical evacuations from theater should be limited so far as possible to persons with persistent psychosis or other clearly disabling neuropsychiatric illness. Where persistent disability is apparent, prompt evacuation is indicated rather than prolonged retention and treatment.
13. HOSPITAL PSYCHIATRY FACILITIES, THEATER OF OPERATIONS: Psychiatric services or sections in hospital facilities in a theater of operations will provide, within the limits of their capabilities, mental health services to their patients and staff and to adjacent base areas in consonance with the concepts and responsibilities described in Section I and paragraph 12 of this regulation.
14. MAJOR MEDICAL COMMAND (MEDCOM) CONSULTANT, PSYCHIATRY:
a. The MEDCOM consultant in psychiatry is assigned to the staff of the MEDCOM Commander in a theatre of operations.
b. The MEDCOM psychiatrist will:
(1) Act as staff consultant in psychiatry, neurology, and mental health to the MEDCOM Commander, discharging the responsibilities enumerated in paragraph 6 (c).
(2) Based on DA policy, formulate for the Commander all policies, directives, and procedures for the mental health program.
(3) Within policies prescribed by the MEDCOM Commander provide medical supervision for all psychiatry, neurology, and mental health facilities and activities in the MEDCOM area.

(4) Provide specific consultation and evaluation certain complicated and special psychiatric and neurologic cases including those proposed for evacuation.

15. REGIONAL CONSULTANT, PSYCHIATRY:

a. The regional consultant in psychiatry is appointed by the [illegible] of the regional hospital commander. He will maintain [illegible] liaison and cooperation with other professional consultants [illegible] levels within the region and with MEDCOM or DA consultants [illegible] problems of mutual professional interest.

5. Functions: The regional consultant in psychiatry will:

(1) Act as staff consultant in psychiatry and mental health to the regional commander, discharging the responsibilities enumerated in paragraph 6 (c).

(2) Based on DA and MEDCOM policy, formulate for the regional commander all regional policies, directives, and procedures for the regional mental health program.

(3) Provide medical supervision, maintain liaison, conduct inspections and training, and take such actions for the regional commander as are necessary to insure that policies pertaining to the Army Mental Health Program are followed.

(4) Insure that high standards of professional work are maintained by the mental health teams at all medical treatment facilities, and in all situations where mental health, psychiatric and neurologic services are offered.

(5) Recommend to the regional commander with the assistance of other appropriate professional consultants, the assignment, utilization, and reassignment of all Army mental health and neurology personnel.

(6) Make recommendations to the regional commander regarding the location and design of medical facilities to provide optimum implementation of the mental health program, optimum psychiatric and neurologic care, and optimum use of mental health and neurology professional personnel.

(7) Initiate, organize, coordinate, and supervise indicated research for the regional commander on problems of military mental health and neurology.

(8) Review boards, courts-martial, and other proceedings involving psychiatric and neurological problems referred to the regional commander.

(9) Survey and monitor items of equipment and supplies necessary to the operation of mental health programs and the provision of a high standard of psychiatric and neurologic care and make appropriate recommendations to the regional commander.

16. MAJOR MEDICAL COMMAND (MEDCOM) CONSULTANT, SOCIAL WORK:

a. The MEDCOM consultant in social work is appointed by the staff of the MEDCOM Commander in a theater of operations.

b. The MEDCOM consultant in social work will:

(1) Act as staff consultant in social work to the MEDCOM Commander, discharging the responsibilities enumerated in para 6(c).

(2) Within the policies prescribed by the MEDCOM Commander, provide social work consultation for all medical treatment facilities in the MEDCOM area.

17. REGIONAL CONSULTANT, SOCIAL WORK:

a. The regional consultant in social work is appointed by the staff of the regional hospital commander. He will maintain [illegible]

liaison and coordination with other professional consultants at all levels within the region and MEDCOM on issues of mutual professional interest.

b. Functions: The regional consultant in social work will:

(1) Act as staff consultant in social work and mental health to the regional hospital commander, discharging the responsibilities enumerated in para 6(c).

(2) Based on DA policy and in close consultation with other professional consultants, formulate for the regional commander policies, directives, and procedures in the field of social work.

(3) Provide technical supervision for the delivery and utilization of social systems assessment and psychosocial adjustment services.

(4) Recommend to the regional commander with the advice of other appropriate professional consultants, the assignment, further training, professional credentialling, utilization, and reassignment of all social work officers within the region.

(5) In collaboration with other regional consultants, initiate, organize, coordinate and supervise research on problems involving the the appropriate application of social work principles.

(6) Survey and monitor items of equipment and supply for the delivery of social work services.

18. MAJOR MEDICAL COMMAND (MEDCOM) CONSULTANT, PSYCHOLOGY:

a. The MEDCOM consultant in psychology is appointed to the staff of the MEDCOM Commander in a theater of operations.

b. The MEDCOM consultant in psychology will:

(1) Act as staff consultant in psychology to the MEDCOM Commander, discharging the responsibilities enumerated in para 6(c).

(2) Within policies prescribed by the MEDCOM Commander, provide psychological consultation for all mental health facilities and activities in the MEDCOM area.

19. REGIONAL CONSULTANT, PSYCHOLOGY:

a. The regional consultant in psychology is appointed to the staff of the regional hospital commander. He will maintain close liaison and coordination with other professional consultants at all levels within the region and MEDCOM on issues of mutual professional interest.

b. Functions: The regional consultant in psychology will:

(1) Act as staff consultant in psychology and mental health to the regional hospital commander, discharging the responsibilities enumerated in para 6 (c).

(2) Based on MEDCOM policy and in close consultation with other professional consultants, formulate for the regional commander policies, directives, and procedures in the field of clinical psychology.

(3) Provide technical supervision for the delivery and utilization of psychological assessments.

(4) Recommend to the regional commander with the advice of other appropriate professional consultants, the assignment, further training, professional credentialing, utilization, and reassignment of all clinical psychologists within the region.

(5) In collaboration with other regional consultants, initiate, organize, coordinate and supervise research on problems

involving the appropriate application of psychological principles.

(6) Survey and monitor items of equipment and supplies for the delivery of psychological services.

SECTION III
Mental Health Program in Garrison, Support, and Training Units

20. GENERAL: Staff mental health personnel in garrison, support and training units will funtion in accord with the concepts and responsibilities in Section I of this regulation.

21. POST MENTAL HEALTH ACTIVITY:

a. General: A Community Mental Health Activity (CMHA) will be established as a separate function at each post supported as a MEDDAC. The primary functions of this installation mental health activity are to establish preventive programs to promote mental health in the military community, and to provide evaluation, care, and treatment services to active duty personnel.

b. Whenever possible, the Community Mental Health Activity will be established apart from the hospital facilities. The consultation, evaluation, crisis intervention, and referral services funtion most effectively in proximity to the military community being served rather than the hospital.

c. The CMHA will function in accord with the concepts and responsibilities enumerated in Section I of this regulation.

d. The C, CMHA will coordinate activity efforts with the appropriate services and departments of the Medical Treatment Facility to include but not limited to the departments of psychiatry and neurology, nursing, and the occupational therapy, psychology, and social work services.

e. The C, CMHA will:

(1) Carry out the professional and staff responsibilities in para 6 (c).

(2) Take part in command consultation and mental health education programs in the military community.

(3) Provide crisis intervention services for all active duty personnel on post, and for dependents/families as resources are available.

(4) Evaluate referrals from all sources including self-referrals.

(5) Supervise the mental health services to the stockade.

(6) Encourage research in preventive mental health and behavioral science.

(7) Recommend reassignment or change of Specialty Skills Identifiers (SSI) in appropriate cases.

(8) Recommend separation from service of individuals who cannot function adequately because of mental or emotional factors.

(9) Evaluate statistical data reflecting types and rates of non-effectiveness associated with psychosocial disorders, and estimate the effects of CMHA methods in their management and correction.

(10) Maintain liaison, coordination, and consultation with other post non-AMEDD human services activities.

f. Time spent with other than activie duty personnel will be on a facility and personnel availability basis, and will not be so excessive as to impair the primary mission.

Nevertheless, it is recognized that the functioning of the military person may be dependent on and interwoven with that of the family, and, therefore, every effort will be made to provide as broad a range of services to the total Army community as

possible. Liaison and coordination will be effected with civilian services and agencies handling the overflow of referrals from the Army community in order to provide as complete and effective a network of mental health services as possible.

c. When a combat division is garrisoned on a post or station where a community mental health activity has been established by the local MEDDAC the relationship between the division mental health activity and the MEDDAC mental health activity will be as described in paragraph 8d. Close liaison, coordination, and cooperation with regard to personnel and facilities will enhance the training experience and functioning of both units and improve services to the Army community.

22. MENTAL HEALTH ACTIVITY, USDB:

a. This activity will, through its assigned mental health team, function to advise and assist the commandant regarding problems of mental health and morale within the USDB community by exercising, where and as practical the staff responsibilities described in paragraph 6 (c).

b. In consonance with para 6-1b, AR190-37 it will:

(1) Advise the Commandant on matters affecting mental health and morale of prisoners, and recommend measures for dealing with problem prisoners where routine disciplinary and treatment measures are ineffective.

(2) Evaluate and make recommendations concerning vocational training and guidance, academic training, rehabilitation, work elements, parole, and other matters pertaining to the assignment and disposition of prisoners.

(3) Provide research and evaluation concerning the causes of prisoners deviant behavior and correctional techniques used and conduct such special research as is indicated.

(4) Maintain statistical records on behavior disorders and pertinent environmental variables such as training, leadership, and morale factors incident to classification and assignment actions. Attention will be given to prisoners attitudes, beliefs, motivation, and social and [illegible] factors.

(5) Develop and supervise group psychotherapy in correctional counseling programs to include crisis and individual psychotherapy and education, recreational, occupational, and reconditioning therapies; and prisoner counseling as set forth in TB MED 36.

(6) Conduct a teaching and training program in preventive mental health for all cadre and [illegible] personnel.

(7) Maintain close liaison with [illegible] classification, training and custody.

(8) Provide consultation [illegible] disposition, and discipline and [illegible] individual prisoners who appear [illegible]

SECTION IV

Hospital Psychiatry and Neurology Facilities in MEDDAC's and MEDCENS

23. ORGANIZATION:

a. A Department of Psychiatry or Psychiatry and Neurology will be established in each hospital where those professions are represented.

b. A Department of Psychiatry and Neurology will be divided, wherever practical, into a General Psychiatry service, a neurology service, a clinical psychology service, a liaison-consultation service, and a child guidance service. Organization of services and within each service and section will depend on staffing, the local mission, and the nature and volume of work.

24. CONCEPTS:

a. The concepts in paragraph 4 are basic to all psychiatry and mental health activities within the Army.

b. The concept and spirit of the mental health team defined in paragraph 5 will be adhered to by policy within the Department of Psychiatry and Neurology and by coordination with the Psychiatric Nursing Section, Social Work and Occupational Therapy Services in order to effectively carry out all applicable staff and professional responsibilities.

c. Individuals will not usually be hospitalized for neurotic symptomatology, personality deviation, or other minor psychiatric conditions, but will be evaluated and treated in outpatient status at the hospital psychiatric clinic or nearest community mental health activity. Exceptions may be made when there is a requirement for diagnostic observation, management of potential suicide, or other safety considerations.

d. Individuals will not be confined or retained in locked facilities unless there is a special indication such as suicidal or homicidal potential, or other indication of danger to self or others that requires such action due to safety considerations. When such indications are present they must be documented prior to confinement or retention on locked wards.

e. The hospital will provide written policies and procedures inclusive of but not restricted to:

(1) Use of locked facilites.
(2) Use of seclusion rooms.
(3) Use of restraints.
(4) Unauthorized absences.
(5) Assaults by patients.
(6) Suicide attempts or gestures.
(7) Patient passes or other authorized absences.
(8) Discharge against medical advice, with particular emphasis on determining indications and need for initiating involuntary hospitalization at appropriate facilities.
(9) Authorized clothing.
(10) Provisions for privacy for patients.
(11) Access to outside communications.
(12) Informed consent for special procedures, for confinement and retention on a locked ward, and for admission to inpatient facilities.

f. Eligible persons other than active duty personnel may be admitted to treatment as an inpatient or outpatient depending on

the availability of facilities and staff. Non-active duty personnel will sign a statment of informed consent for admission to psychiatry inpatient facilities prior to being admitted. If there is a question of mental competency, the statement will be witnessed by next of kin or other legally constituted authority.
6. Prisoners, unless psychotic, will not be housed on psychiatric wards with psychiatric patients. In no instance are guards on a psychiatry ward to be armed.
27. FUNCTIONS:
a. Staff:

(1) The Chief, Department of Psychiatry and Neurology will lead the hospital mental health team in fulfilling those staff responsibilities in paragraph 6 (c) which are applicable. Special attention will be given to maintaining liaison with both medical and line staffs within the catchment area of the hospital as well as the hospital itself.

(2) The Chief will insure that criteria are developed for the granting of individual clinical privileges in Psychiatry, Neurology, and allied mental health professions in harmony with AR40-400.
b. Professional:

(1) The Department of Psychiatry and Neurology will, consonant with the credentials and clinical privileges of the available professional and allied personnel:

(a) Furnish the highest possible standard of treatment to all patients assigned or referred.

(b) Insure that an education and training program exists for all members of the mental health staff.

(c) Conduct and document and education and training program for the assigned medical staff.

(d) Perform research and report on significant clinical findings.

(e) Provide liaison/consultation services to the hospital medical staff.

(f) Maintain clincal records in accord with the applicable ARs, good clinical practice and legal, ethical, and accreditation standards.

(2) The Psychiatry Services will:

(a) Operate one or more inpatient treatment sections, an outpatient clinic, and a liaison consultation section as indicated; will provide adequate space for activities, programs, and modalities offered; will engage in discharge planning which will involve the patient, patient's family and/or the patient's unit commander and which will insure continuity of care; will provide referral arrangements with other medical and social services within the hospital and the community; will, so far as possible, insure that trained nursing and allied mental health personnel are assigned to the care and treatment of psychiatric patients on a stabilized basis; and will conduct medical care evaluation studies in harmony with AR 40-400 and standards of the Joint Commission on Accreditation of Hospitals.

(b) The psychiatric outpatient service medical record will be created and include applicable data from the following list for each episode resulting in the provision of mental health services. Vital data including patient identification, name and next of kin or other responsible agent, identification of other source of

mental health services, and dates and times of visits; clinical data including working diagnosis or patient's clinical problems, pertinent medical history including past history, physical examination and mental status reports, consultation reports and clinical data from other providers, clinical notes and laboratory data, closing summary, and disposition including any plan for follow-up care; treatment and instructions to include notation of prescriptions written, diet instructions as applicable, and self-care instructions. When certain parts of the patient's medical record are stored separately for reasons of privacy, these must be made part of the complete record for medical evaluation studies. Criteria will be established for the review of both outpatient and inpatient records.

(c) The Psychiatry service will provide consultant, diagnostic and treatment services to referred inpatients and outpatients. In particular the patient's records will document that psychiatric consultation was requested for and/or offered to all patients seen throughout the hospital who have attempted suicide or have taken a chemical overdose.

(3) The Neurology service will operate an inpatient treatment section, a neurology outpatient clinic, an electroencephalographic laboratory, and other electrodiagnostic procedures as indicated.

(4) The Clinical Psychology service will provide inpatient and outpatient evaluation, treatment, and consultation in accord with the professional education, training, experience, and credentialing of the staff assigned.

(5) If established, the Child Guidance service will provide outpatient evaluation and treatment to military families and dependent children. Professional consultation may be offered to dependent schools and other agencies that deal with the problems of children in the Army community.

Task Group Four

Alcohol and Drug Abuse

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Objectives of Task Group Four

on

Alcohol and Drug Abuse

Review the Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) as it relates to the Army Medical Department (AMEDD); identify inadequacies and deficiencies in the program; and make recommendations for program improvement.

Observations and Recommendations of Task Group Four

on

Alcohol and Drug Abuse

1. OBSERVATION. A broad "grey area" exists in the ADAPCP where the Command responsibilities for rehabilitation blend into the AMEDD responsibilities for treatment. In order to more precisely define who, command or AMEDD, should be performing which functions, Task Group Four divided the alcohol and drug abuse population at risk into four groups and attempted to relate each group to functional areas of responsibility within the ADAPCP.

a. With regards to alcohol and drug abuse, the military population may be divided into four groups.

(1) Non-users - Those who do not use abusable substances.

(2) Users - Those who use abusable substances but whose use and/or abuse goes undetected.

(3) Non-dependent abusers - Those users identified as abusers but who show no evidence of psychological or physiological dependence on abusable substances.

(4) Dependent abusers - Those users identified as abusers who are psychologically or physiologically dependent on one or more abusable sub-

stance.

b. The four population groups relate to ADAPCP areas of responsibility in the following manner.

(1) Both non-users and users are target populations for Command education and prevention programs with the goals being to discourage use/abuse by the non-user; to influence the unidentified user to discontinue abuse before getting into difficulty; and to cause identified abusers to discontinue abuse as a requirement for remaining in the military.

(2) Non-dependent abusers are best managed in a Command setting by administrative action and leadership type counseling.

(3) Dependent abusers require treatment/rehabilitation of the type normally provided by clinical professionals through a health care delivery system, i.e., the AMEDD.

(4) Detoxification, medical treatment of complications of substance abuse and psychiatric care of those with other associated mental disorders are AMEDD functions.

(5) Unidentified abusers are the target population for both Command and AMEDD identification efforts. Goals of identification are to isolate and remove from duty those who are a threat to mission completion; to treat and rehabilitate those who are having difficulty as a result of substance

abuse; and to remove from military service those who fail to be rehabilitated in the ADAPCP or who are found to be medically unfit for retention in the military.

(6) The AMEDD is responsible for the laboratory support of the urinalysis drug screening program.

(7) The AMEDD is also responsible for Biomedical Research on substance abuse.

c. AMEDD responsibilities to the ADAPCP may then be summarized as follows:

(1) Provide consultation to Command on the medical/clinical aspects of education, prevention, identification, evaluation, rehabilitation, disposition, and follow-up functions of the ADAPCP.

(2) Provide clinical expertise to perform client evaluations, assist in counseling non-dependent abuses and provide clinical in-service training of ADAPCP personnel.

(3) Provide both residential and non-residential rehabilitation for dependent abusers; either in separate Rehabilitation Services or through existing Community Mental Health Activities at AMEDD Medical Treatment Facilities.

(4) Provide medical treatment for the complications of substance

abuse and for concurrent medical or psychiatric problems.

(5) Provide the laboratory facilities and personnel necessary to execute the urinalysis drug screening program.

(6) Conduct research in the biomedical aspects of Army unique [illegible] of substance abuse.

Recommendations:

a. That the AMEDD continue to be a major contributor to the Army ADAPCP.

b. That the rehabilitation aspects of the program continue to be a function of the AMEDD health care delivery system.

2. Observation: The efficacy of residential treatment/rehabilitation of the chronic alcoholic and other selected kinds of chronic substance abusers has been more than adequately demonstrated by the civilian medical community, other military services and the Army in Europe. The Army would realize further significant dollar and manpower savings by employing this treatment modality Army wide. At the same time, it would significantly reduce morbidity and mortality caused by one of the Army's major preventable health problems.

Recommendation: That the Army take immediate action to establish residential treatment/rehabilitation centers in CONUS for alcoholism and [illegible]

selected types of chronic substance abuse.

3. Observations: The Behavioral Science Specialist [illegible] does not receive sufficient training to be qualified as [illegible] and there is no other MOS designed to perform this function.

Recommendation: That the Army review its requirements for [illegible] counselors and precisely define what qualifications the [illegible] Consideration should be given to awarding a special [illegible] not a separate MOS, to those personnel [illegible] ing. A good starting point would be to examine [illegible] alcohol and drug abuse counselor program which [illegible] Selection criteria for [illegible] career NCO, [illegible] if a recovering alcoholic, [illegible] remain in counseling field [illegible].

4. Observation: A sufficient part of the [illegible] including the Army, [illegible] drugs. This includes [illegible] dosages, side effects, [illegible] dependence, [illegible] reactions with alcohol and other [illegible] minor tranquilizers, sedatives, [illegible] and alcohol [illegible]

Recommendation: That urgent priority be given to [illegible]
termination of [illegible]

5. Observation: It [illegible] that [illegible] hospital admissions [illegible] orders are due to drug [illegible] admission. This can result in persons being improperly labeled [illegible] psychiatric cripples rather than as having experienced a temporary and reversible toxic psychosis. Needless morbidity, unnecessary disability, expense is the end result. The already operative toxicology drug screening program could serve as a useful clinical research tool if it were to be used to evaluate all psychiatric hospital admissions for drug [illegible] and thus document the less dramatic toxic reactions.

Recommendation: That for a 24 month test period, all patients admitted to Army Treatment Facilities with a psychiatric diagnosis have a drug screen done on a urine specimen collected at the time of initial admission. This should be accomplished as a part of the initial clinical work-up.

6. Observation: Because some studies indicate that a few "alcoholics" return to "controlled social drinking," some Army treatment personnel are reluctant to establish "total abstinence" as a reasonable treatment goal for the chronic alcoholic. However, it is not possible, using state of the art technology, to differentiate those who can drink from those who cannot. It is therefore reasonable to use abstinence as a treatment

the physiologically addicted alcoholic in the Army, where unsuccessful return to controlled drinking may result in "rehabilitation failure" and separation from the service. This should be a clinical goal in the treatment process, not an administrative goal in determining rehabilitation success.

Recommendation: That abstinence be a clinical goal in treating the chronic physiologically addicted alcoholic in the Army ADAPCP.

7. Observation: While most alcohologists recognize the benefits to be gained by referring patients to Alcoholics Anonymous (AA) as an integral part of their rehabilitation program, many counselors, supervisors and clinical directors in the Army ADAPCP elect to treat without utilizing this valuable resource. This deprives the patient of an opportunity to become part of this lifetime support system, lessens the potential effectiveness of the Army program and increases professional resource requirements by substituting critically short clinical resources for an effective self help program.

Recommendation: That, as a matter of ADAPCP policy, all alcoholic clients/patients be introduced to the Alcoholics Anonymous (AA) program through required attendance of AA meetings during the active phase of rehabilitation. Participation in the AA program should be recommended as part of continuing treatment following rehabilitation.

Task Group 5: CHAMPUS

1. Membership: Chairman - LTC Terry Gagon, MC, Chief, Psychiatry Clinic, WRAMC; Maj Kenneth Gunnell, Clinical Nurse Specialist, LAMC; Col Harold L. Plotnick, Social Work Svc, Rutgers Univ; LTC Robert G. Bleck, Child Guidance Clinic, FAMC; 1LT Fredrick J. Terrell, Psychologist, Mental Hygiene, Ft. Leavenworth; Maj Frank H. Rath, Jr., Psychology Consultant, Dept of Psychiatry, Heidelberg Hospital; Doris Callender, New Directions Svc, FAMC; Col Franklin Del Jones, MC, P & N Consultant, Pentagon; LTC Jack McInroy, MS, USAF, Academy, Colo.

2. The task Force on CHAMPUS specifically addressed problems involving:

a. general slowdown of reimbursement and difficulties in true administrative national oversight of the fiscal intermediaries by the CHAMPUS organization

b. problems involving the lack of adequate consumer feedback to OCHAMPUS

c. problems involving health planning for intermediate care and residential treatment

d. problems involving the optimal intensity and implementation of the APA DOD Peer Review Contract centering on inadequate provision explicitly worked out for protection of confidentiality. Further difficulties involving latitude of responsibilities for the "second level" nurse reviewer appeared to in some instances circumvent true formal peer review. A cumbersome appeals process modeled after that of the Social Security Administration could occur prior to true formal peer review.

3. The Task Force began with a presentation by Dr. Gagon on Tuesday, 20 March 1979 of an overview of current research regarding the epidemiology of mental illness, incidence rates for both mental health and general medical services. Data from ongoing projects at NIMH and from other settings were presented to show the predictability and feasibility of full funding for mental health in health care systems. The "offset hypothesis", namely that funding for mental health care in various medical plans actually diminishes total utilization of general medical services, was discussed at length. Dr. Gagon also summarized the history of the CHAMPUS Peer Review Project in order to orient the Task Force Members for planned discussions with OCHAMPUS officials for the following day.

4. On Wednesday the Task Force met with Mr. Norman Penner, Project Director at the American Psychiatric Association for DOD CHAMPUS Peer Review Project; Dr. Claiborn, Director, CHAMPUS Project, American Psychological Association; Dr. Paul Hoffman, MD, USAF, MC, Medical Consultant in the Quality Assurance Branch of the Program Evaluation Division of OCHAMPUS; Mr. Wagner, Consultant, Program Evaluation Division of OCHAMPUS. On that day the areas of concern noted above were discussed at length between the consultants and the Task Force Group. The OCHAMPUS representatives outlined the

new CHAMPUS organizational plan indicating that it was their hope that CHAMPUS would operate much more effectively with the recent reorganization. Dr. Hoffman stressed the ongoing concern for developing guidelines for appropriate medical care in all areas. CHAMPUS officials outlined the history of congressional concern with the CHAMPUS program involving what in the early 19[illegible] been in essence a failure on the part of OCHAMPUS to specify exclude some inappropriate kinds of funding. Dr. Hoffman stressed the administrative problem of reestablishing CHAMPUS benefits each time a claim is submitted. There was a general discussion of a problem with the fiscal intermediaries which had developed when under congressional mandate CHAMPUS was required to let its contracts to the lowest bidders. In some instances the fiscal intermediaries who obtained the contracts were not adequately prepared to handle the administratively complex processing of volume of claims submitted. Mr. Penner and Dr. Claiborn outlined the history and philosophy of the DOD Peer Review Project and there was a lively discussion of the question of the "[illegible] nurse reviewer's responsibilities as well as the possibility that under the proposed protocol the extreme frequency of formal peer review appeared to be economically and bureaucratically cumbersome from the point of view of Task Force members. Dr. Wagon compared the program in effect with that of the Medical Service the District of Columbia as an example in which there was an [illegible] process of review of quality medical care which led to a necessity of true formal peer review in only about 1% of claims submitted. The need for an establishment of explicit and public confidentiality guidelines for the peer review information was stressed by Task Force members. There was a general discussion of the economics of third party payment systems which centered on the problem of a kind of skewing of CHAMPUS cost data when a consideration of variability in the direct system provision of care in various medical specialty areas was not taken into account. In the area of intermediate care and residential treatment the CHAMPUS officials stressed the history of abuses in adolescent residential treatment centers which had led to congressional mandates for strict [illegible] control cost accounting in that area. Because states have responsibility for training programs for the mentally retarded and disabled there are many situations in which service families face the problem of finding an adequate state-run program for special needs involving handicapped family members. It was noted that it was the philosophy of OCHAMPUS to encourage the abrogation of this full responsibility by the states except in very unusual circumstances.

On Thursday, 22 March 1979 the Task Force discussed the consultations with National CHAMPUS [illegible] of the previous day. Late during that day Dr. Wagon and [illegible] the new National Director of CHAMPUS [illegible] meeting all of the concerns of the Task Force [illegible] in depth with Mr. Wood.

6. On Friday, the findings from the Task Force were presented to the plenary session of the Behavioral Science Seminar. The Task Force members agreed that the specific recommendations arrived at during the week would be incorporated in an Action Paper with an attempt at triservice coordination, followed by presentation through the Office of the Consultant in Psychiatry and Neurology to the Army Surgeon General. The Action Paper would be made available to appropriate policy planning officials at OCHAMPUS. This was carried out during the weeks following the Task Force. The Action Paper with attachments are enclosed as an appendice to this Task Force Report.

Incl
as stated

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REPLY TO
ATTENTION OF:

HSWP-R

11 May 1979

Subject: Recommendation for Action Regarding CHAMPUS Care for Mentally Ill

1. Statement of Problems:

a. Over the past two years there has been a breakdown in the provision of psychiatric services under OCHAMPUS. This has involved delays in payments often for three to six months, bureaucratic harassment, ill-defined guidelines for approved services which have at times been interpreted idiosyncratically by the ten CHAMPUS fiscal intermediary agencies and threatened interruption of payments during ongoing treatment. Demoralization of patients, providers and military psychiatrists has resulted.

b. There has been a breakdown of well-functioning avenues for the inclusion of policymaking input from military psychiatry in areas of mutual concern to the direct care system providers and OCHAMPUS.

c. There is no adequate avenue for feedback to OCHAMPUS from beneficiaries and providers.

d. There are three special problems in the implementation of the DOD Contract with the American Psychiatric Association and the American Psychological Association for the CHAMPUS Psychiatry Peer Review Project:

1) Decision authority has been delegated downward to the 'second level' nurse reviewer confounding clinical and administrative decision making regarding peer review. This gives power to deny claims for medical care in areas of fine clinical judgement to non-peer personnel. In essence the nurse practices medicine and psychology in violation of standard medical codes of ethics.

2) A standard operating procedure (SOP) for protection of confidentiality of very sensitive clinical information to be submitted for psychiatric peer review on every patient has not been fully established and clarified to patients, sponsors and providers. This SOP should involve beneficiary input prior to its full implementation.

3) The present implementation plan for the peer review project allows for claim denial in areas of clinical judgment prior to guaranteed true peer review, with the only recourse being a cumbersome and bureaucratically time-consuming appeal process modeled after the one utilized by the Social Security Administration.

2. Recommended Corrections:

a. OCHAMPUS should implement a strict ongoing national oversight program for evaluation of its various fiscal intermediaries. Managerial improvements should include educational workshops for uniformed services health benefits advisors, [illegible] fication and clarification of regulations to the fiscal intermediaries, and significant improvements in timely processing of claims or changes to the regulations.

b. Critical assignments should be made:

1) The office of the Assistant Secretary for Health Affairs, vacant for nearly two years, should be filled as soon as possible. This official should receive immediate briefings from the Defense Health Council regarding the identified problem areas.

2) Each Uniformed Service should mandate the assignment of a senior medical officer of flag rank to the Defense Health Council, the main avenue of input from military medicine to OCHAMPUS. Military psychiatrists should be tasked to provide ongoing staffing to these officers regarding the cost, [illegible] mental disease conditions and policies.

c. Changes in certain practices should be made:

1) The uniformed services are responsible for the health benefits advisors. Commanders should mandate [illegible] training and attendance at OCHAMPUS sponsored workshops. The CHAMPUS beneficiary should be routinely counseled by the health benefits advisor upon referral to CHAMPUS care for all [illegible] assistance regarding procedures which are necessary for administrative compliance with CHAMPUS regulations.

2) A clear beneficiary and provider [illegible] should be established and publicized. First the beneficiary's complaints should go to the health benefits advisor. If not resolved they should go to a specific [illegible] representative at the fiscal intermediary level. If still not resolved they should go to the liaison officer [illegible]

HSWP-R 11 May 1979
SUBJECT: Recommendation for Action Regarding CHAMPUS Care for Mentally Ill

uniformed service at the Denver OCHAMPUS. This officer has access to the entire internal OCHAMPUS organization.

d. Reviewing processes require revision:

1) If the 'second level' nurse reviewer determines that in 'gray zone' areas of clinical judgment claim denial may be warranted, then 'third level' or true peer review should be made automatic, not ex post facto after a cumbersome appeals process when a claim is denied.

2) OCHAMPUS should establish and make available to beneficiaries, health benefits advisors, providers, military psychiatrists, and concerned professional medical societies a strict SOP which safeguards the confidentiality of sensitive clinical peer review information. There is extensive precedent for such protection in the Social Security Act, the Federal Alcohol and Drug Abuse legislation, the PSRO law, HEW guidelines and the Privacy Act.

3) Formal true peer review should precede all claim denial except in areas specifically denied by regulation.

3. Appended is reference material bearing on these matters.

TERRY E. GAGON, MD
LTC, MC, USA
Chairman, CHAMPUS Committee
Army Psychiatry Advisory Council

Chief, Psychiatry Outpatient Service
Department of Psychiatry
Walter Reed Army Medical Center

DEPARTMENT OF THE ARMY
WALTER REED ARMY MEDICAL CENTER
WASHINGTON, D.C. 20012

REPLY TO ATTENTION OF:

A-1

HSWP-R 27 February 1979

SUBJECT: Recommendation for Action

1. Relevant factual information concerning psychiatric care in this country (Inclosure 2).

a. 15% of the population per year is estimated to exhibit an alcohol, drug abuse or mental condition.

b. 20% of this group is treated by the Specialty Mental Health Sector; 60% of those with identified mental disorders are treated by primary care/outpatient medical treatment, non-psychiatrists.

c. Patients with identified mental disorders utilize general medical services at a rate that is at least double that of other patients.

2. Relevant factual information concerning medical health insurance coverage for mental health conditions:

a. The $150 billion total health care bill is not the result of abuse of preventive and long-term care; it is primarily the result of abuse of secondary and tertiary care.

b. After 15 years of experience, the proportion of total health benefit payments spent on mental disorders in the Federal Employees Program has leveled off at a little over 7%, showing that equal coverage for mental and physical illness does not lead to exhorbitant costs for mental illness.

c. There is overwhelming evidence that effective mental health treatment is followed by reduction in general medical care utilization. The offset reductions are as follows:

1) Hospital days . . . . . decreased by 67% to 85%
2) Outpatient visits . . . . . decreased by 50% to 72%
3) Physician's services. . . . . decreased by 8% to 31%
4) Medical visits. . . . . decreased by 11%
5) Lab and X-ray service . . . . . decreased by 15% to 28%
6) Total medical expenditures. . . decreased by 31%

d. Only 8% of the nation's mental health benefits are paid to private psychiatrists, the great proportion going to hospitals, nursing homes, and rehabilitative care facilities.

HSWP-R 27 February 1979
SUBJECT: Recommendation for Action

3. Relevant factual material regarding proposed CHAMPUS Psychiatric Peer Review Project guidelines sponsored by DOD:

a. CHAMPUS regulations require that all claims for psychiatric outpatient service be submitted with no more than eight visits per claim and that the 8th, 24th, and 40th outpatient session must be reviewed by a second level (i.e., nurse) reviewer.

b. All psychiatric outpatients continuing to the 60th outpatient session must be referred for peer review by a panel of three physicians, each of whom evaluates the case separately followed by a vote.

c. All claims for inpatient service must be reviewed by second level reviewer at the 20th inpatient day and referred to peer review at the 60th inpatient day of hospitalization. Again, three independent physician peer review evaluations and a vote are required for every patient.

d. Decision authority has been delegated downward to the maximum extent possible with confounding of clinical and administrative decision making converging in the second level nurse reviewer, who has the power to deny claims. In essence, the nurse practices medicine.

e. While considerable authority and responsibility are entrusted to the second level reviewer (nurse), no professional or educational credentials or job experience are specified for this position which requires considerable professional integrity and competence. This specifically violates established principles of peer review in the American Medical Association and the American Psychiatric Association. Section 6 of the APA Code of Ethics states, "the physician should not delegate to the psychologist or, in fact, to any non-medical person any matter requiring the exercise of professional medical judgement". The interest on the part of DOD to devise a simplified method for review of all psychiatric claims by utilizing non-physican personnel has totally overloaded the system and removed the possibility of refined clinical judgement truly necessary for peer review. By contrast, senior Federal Employees Program officials indicate that less than 1% of the [illegible] psychiatry claims require formal peer review.

f. Special handling of claims from psychiatric patients has already led to a serious discriminatory delay in payment for [illegible]; for example, at the present time, the turnaround time for non-psychiatric CHAMPUS claims at the Roanoke office is 37 days (legal requirement is 21 days). Officials could not even estimate the time for psychiatric claims--over 100 days. The Washington Psychiatric Society Council states that the delay for psychiatric claim

payment now averages six months per claim. Often the second review procedure point is reached before the first review is completed.

g. No systemized consideration is given to the problem of confidentiality. Psychiatric records are considererd permanent, whereas other medical records are maintained for only four years.

h. Persisting attitudes at high levels in the DOD-CHAMPUS organization toward the provision of psychiatric care for the mentally ill or disabled have reflected a lack of knowledge regarding the epidemiology of mental illness, proved predictability of cost projections, offset of other general health care costs by psychiatric treatment paradigms, and the usefulness of well-established treatment modalities (Incl 3, p. 3, para 3).

4. Conclusions and Specific Recommendations:

a. While military psychiatry agrees with the inherent philosophy and goals of peer review, present guidelines from the CHAMPUS Psychiatric Peer Review Project require further study before implementation for the following reasons:

1) Peer review should indeed be true peer review even at the "second level" of review, not in violation of standard medical codes of ethics. The stated policy of delegating the authority and responsibility often of a clinical nature to relatively untrained employees is in defiance of these well-established procedures for peer review and medical ethics.

2) Military psychiatry has not been represented formally in the decision-making process within the DOD-CHAMPUS organization. We would recommend the appointment of a military psychiatrist to the CHAMPUS Psychiatric Peer Review Project at a decision and policy-making level.

3) Implementation of peer review should await further study and clarification of issues of confidentiality of sensitive clinical data.

4) Accountability procedures, such as peer review, must be implemented in such a way as to be truly responsive and sensitive to the needs of the mentally ill in our community, rather than dogmatically giving allegience to technocratic economics. These needs are epidemiologically predictable and do not lead to cost overruns.

5) The implementation of the CHAMPUS procedures to date regarding the provisions of psychiatric services under the DOD contract has resulted in significant interference with the psychiatric care received by the dependents of the military by

delays in payments, bureaucratic harassment, ill-defined guidelines, threatened interruption of payments during ongoing treatment, and a general insensitivity to the issues of confidentiality with subsequent demoralization of not only patients and providers, but also military psychiatrists. This state of affairs contrasts sharply with that of the Federal Employees Program peer review process, which is designed not to intrude excessively into claims processing by a randomized process which does not treat every single case as requiring peer review. Such extensive screening should not be made routine, as though every psychiatric patient and provider were suspect.

6) CHAMPUS should be increasing and facilitating psychiatric health benefits at a time when military psychiatry is suffering from a crisis of attrition. Presently, the Army has only 136 psychiatrists for 180 authorized positions, a shortfall of 25%. Recognized requirements for Army psychiatry approach 300, a shortfall of 45%.

Terry E Gagon

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January 5, 1978

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH SERVICES

THE NEED TO PLAN FOR THEIR INCLUSION IN A NATIONAL HEALTH INSURANCE PROGRAM

A. ADM Conditions and Their Prevalence

1. ADM disorders constitute a significant health problem in the U.S., which is definable in terms of:

   a. the overall scope of the problem -- about 15% of the population per year

   b. a relatively small number of specific disorders which represent the bulk of this 15% (There is some overlap among some of these conditions, e.g., a person with alcoholism may also be depressed.)

2. In addition to the 10 - 15% of the population with definable ADM conditions, there are many other individuals who are troubled with symptoms and distress such as anxiety, transient stress, problems of living, and unhappiness. They often turn to the health care system for help. This is the case in many nations.

B. The Structure of the ADM System

1. The ADM system has a structure with two main components:

   a. the general health care sector (serving about 15% of the population for ADM disorders)

   b. the ADM specialty sector (serving about 1% of the population for ADM disorders)

2. The vast majority of patients with ADM disorders is identified by and receives some treatment in the general health care sector, predominantly ambulatory primary care.

3. The ADM specialty sector has undergone considerable change in the past twenty years:

   a. The number of residents in State and county mental hospitals has significantly declined since 1955.

   b. The length of stay in State and county mental hospitals has declined.

   c. The rate of admissions to all inpatient psychiatric units has remained approximately constant.

   d. The number and rate of patients being treated in outpatient settings has increased greatly.

   e. The use of a wide variety of drug therapies has increased greatly.

   f. Overall, patients are being treated in less expensive settings.

4. The pattern of utilization of the ADM services sector is now quite similar to that in the general health care sector, as to:

   a. relative use of inpatient and ambulatory care facilities

   b. average duration of treatment

   c. evidence about the efficacy of treatment

   d. proportion of patients requiring extensive care

5. Extensive data exist on the utilization, costs, and types of ADM disorders treated, and efforts are underway to extend and refine this data base in concert with other parts of the PHS.

C. Planning Goals and Planning

1. A major goal of planning should be to achieve appropriate integration of the ADM services sector with the general health care sector.

2. A second major goal of planning should be to strengthen the capacity of the general health care sector to identify and appropriately treat ADM disorders.

3. Current funding mechanisms impede the integration of ADM services with the general health care sector.

4. Selective use of funding mechanisms can shape the future structure and costs of ADM services.

5. ADM services can reduce general health care costs and lead to more appropriate patterns of care.

6. Greater integration of services can lead to a reduction in the utilization of ADM specialty services.

7. Comprehensive, integrated services will contribute to a redistribution of ADM specialty resources so as to increase geographic and economic accessibility.

8. A comprehensive system would accelerate the current trend to shift patients with ADM disorders away from expensive inpatient settings and toward less expensive alternatives, such as ambulatory care settings.

9. ADM services are amenable to the same cost containment and quality assurance mechanisms that apply to general health care services.

10. The costs associated with providing ADM services are controllable, and stable and predictable.

D. National Health Insurance

1. Persons with ADM disorders are entitled to full participation in the health care system.

2. NHI should not stigmatize and discriminate against persons with ADM disorders.

3. Depending on its design, NHI can foster continued improvements in the MH service system, as well as increased integration of these services with the general health care system.

4. Even with NHI, the health care system will require multiple funding mechanisms, including:

   a. third-party reimbursements

   b. grant and contract support, for capacity development in health scarcity areas and for R and D projects

   c. block grants or funds from the Federal Government, such as special health revenue sharing, block grants, or formula grants, to support activities of State and local health program development

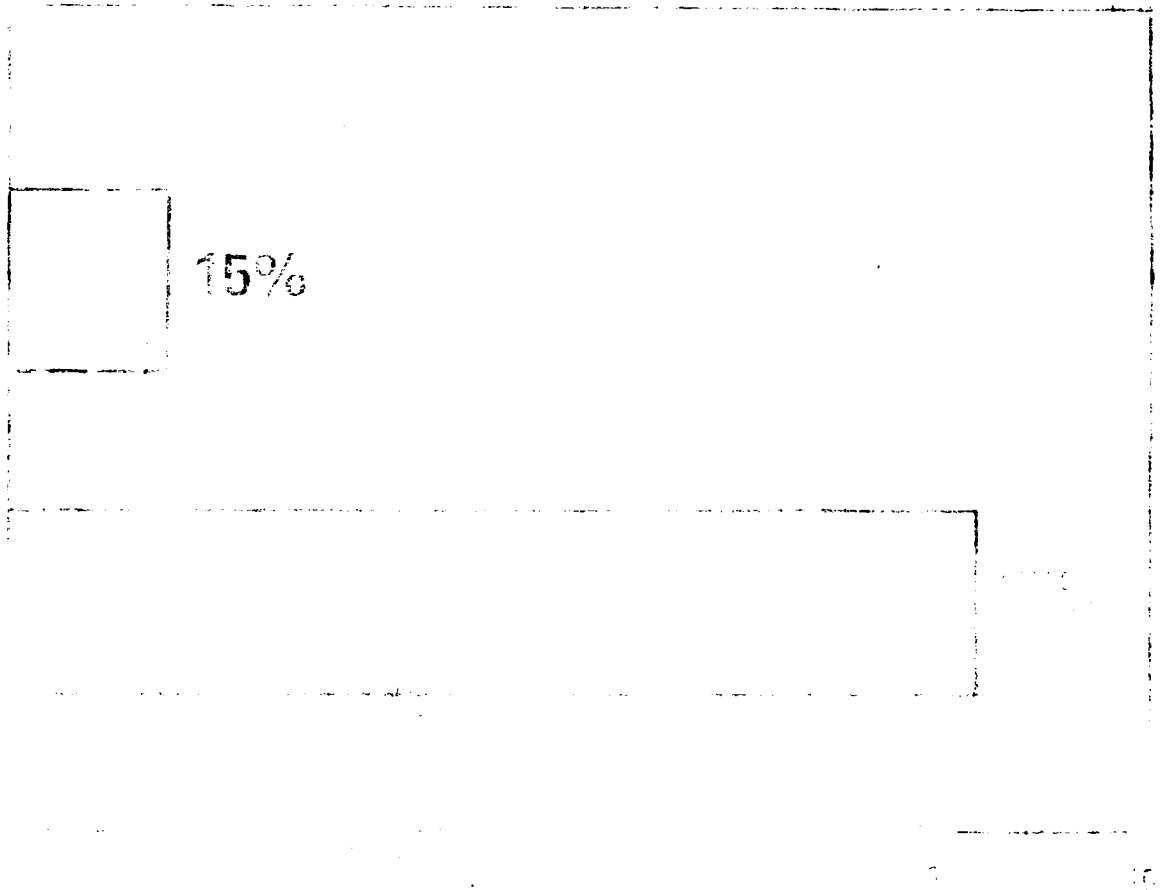
   d. support for social services

   e. categorical support for preventive, treatment, and rehabilitative services not likely to be covered by NHI, such as sheltered living arrangements, outreach, and consultation and education activities

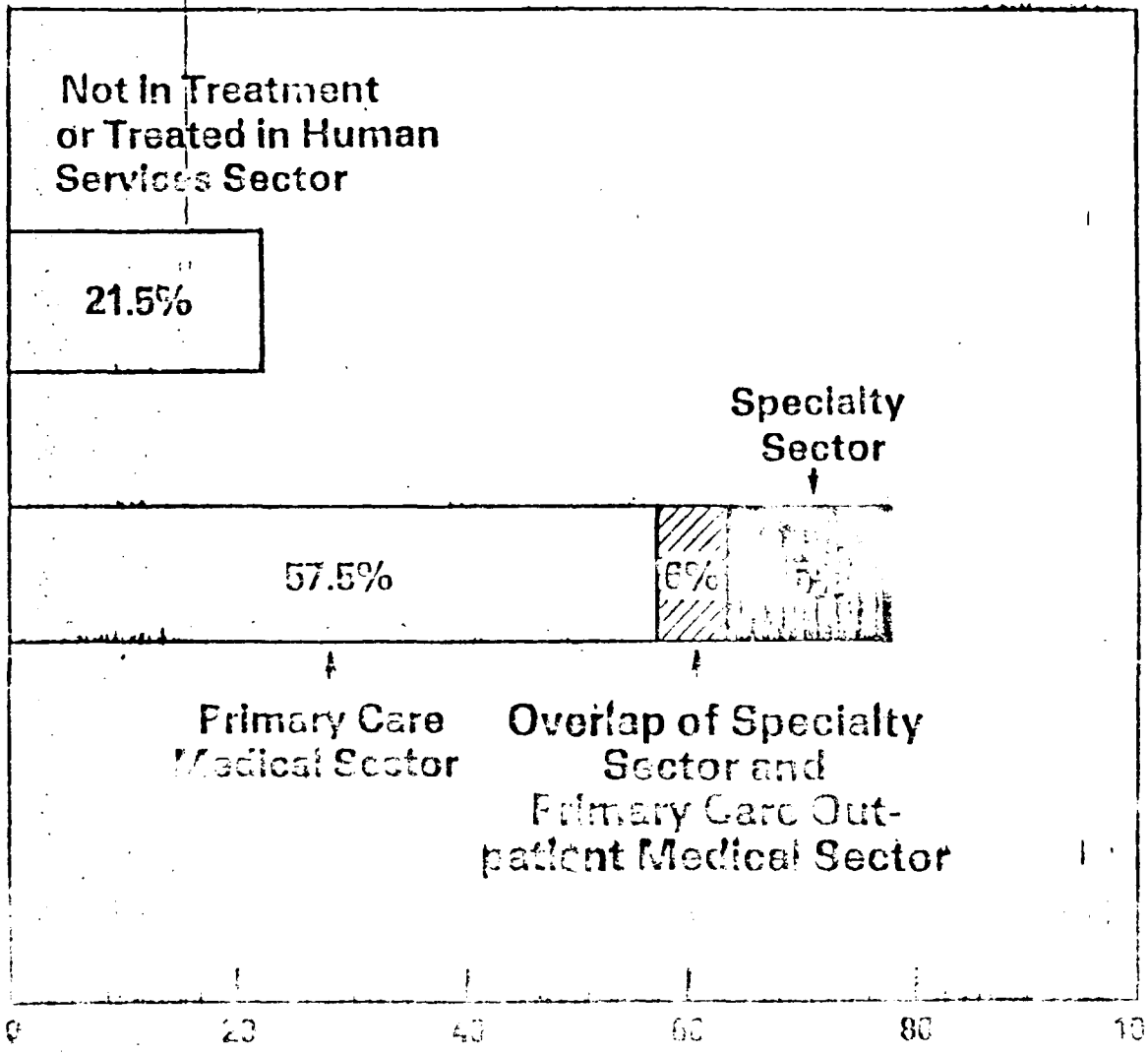
ESTIMATED PREVALENCE OF SELECTED ALCOHOL, DRUG, AND MENTAL DISORDERS

Disorders by Age Category	Point Prevalence (rate per 100 persons)
Children (under 18)	8-10%
Adults (18-65)	10-15%
Depression and Affective Disorders	4.5-8%
Anxiety, Phobia, and Other Neuroses	4-7%
Alcoholism and Alcohol Problems	2.5-8%
Drug Dependence	0.5-1%
Schizophrenia	0.5-1%
Aged (over 65)	10%

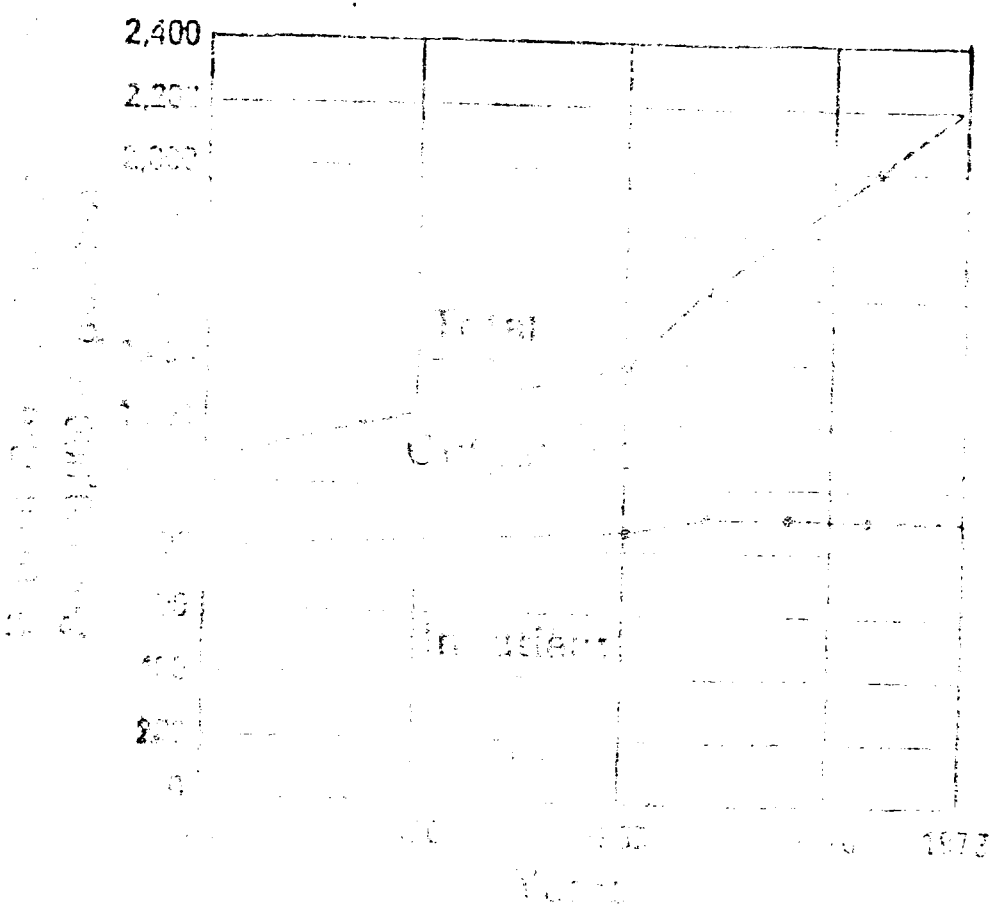
ESTIMATED PERCENT OF U.S. POPULATION WITH ALCOHOL, DRUG, OR MENTAL DISORDER DURING YEAR 1975



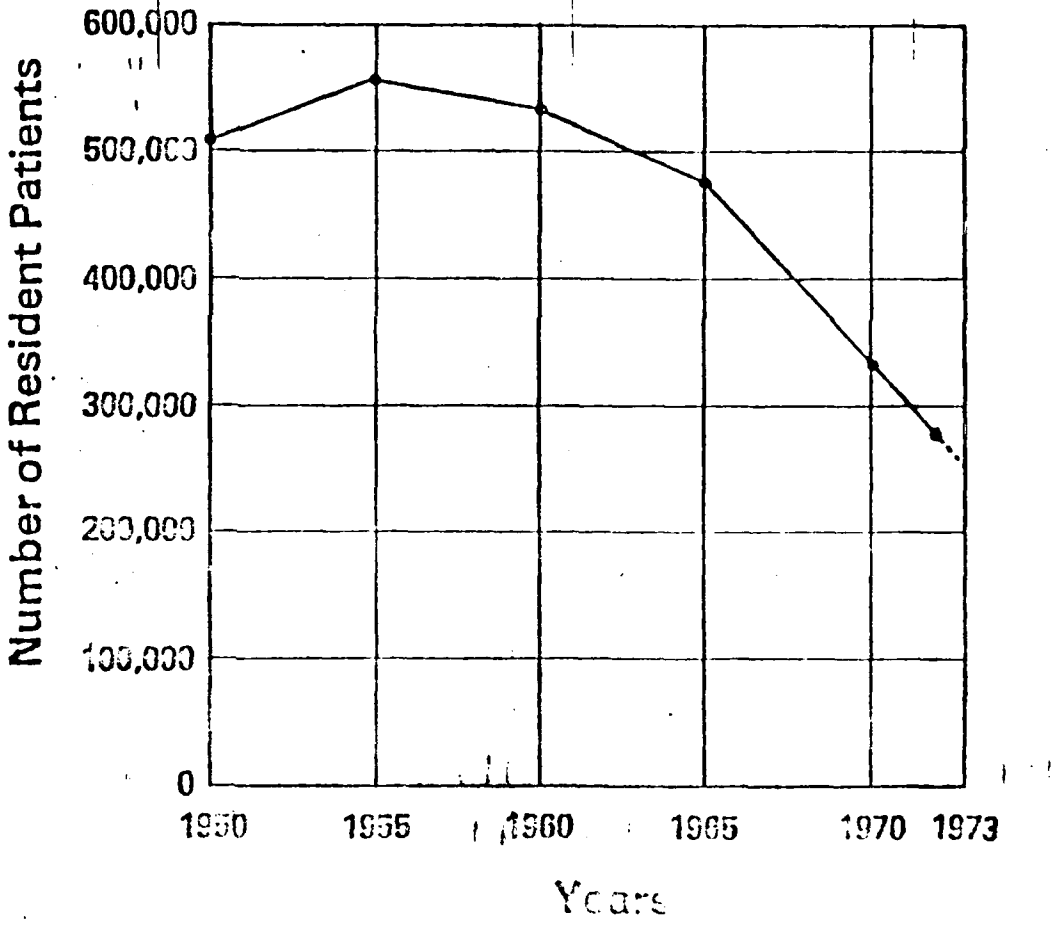
ESTIMATED PERCENT DISTRIBUTION OF PERSONS WITH ALCOHOL, DRUG, OR MENTAL DISORDER, BY TREATMENT SETTING, UNITED STATES, 1975



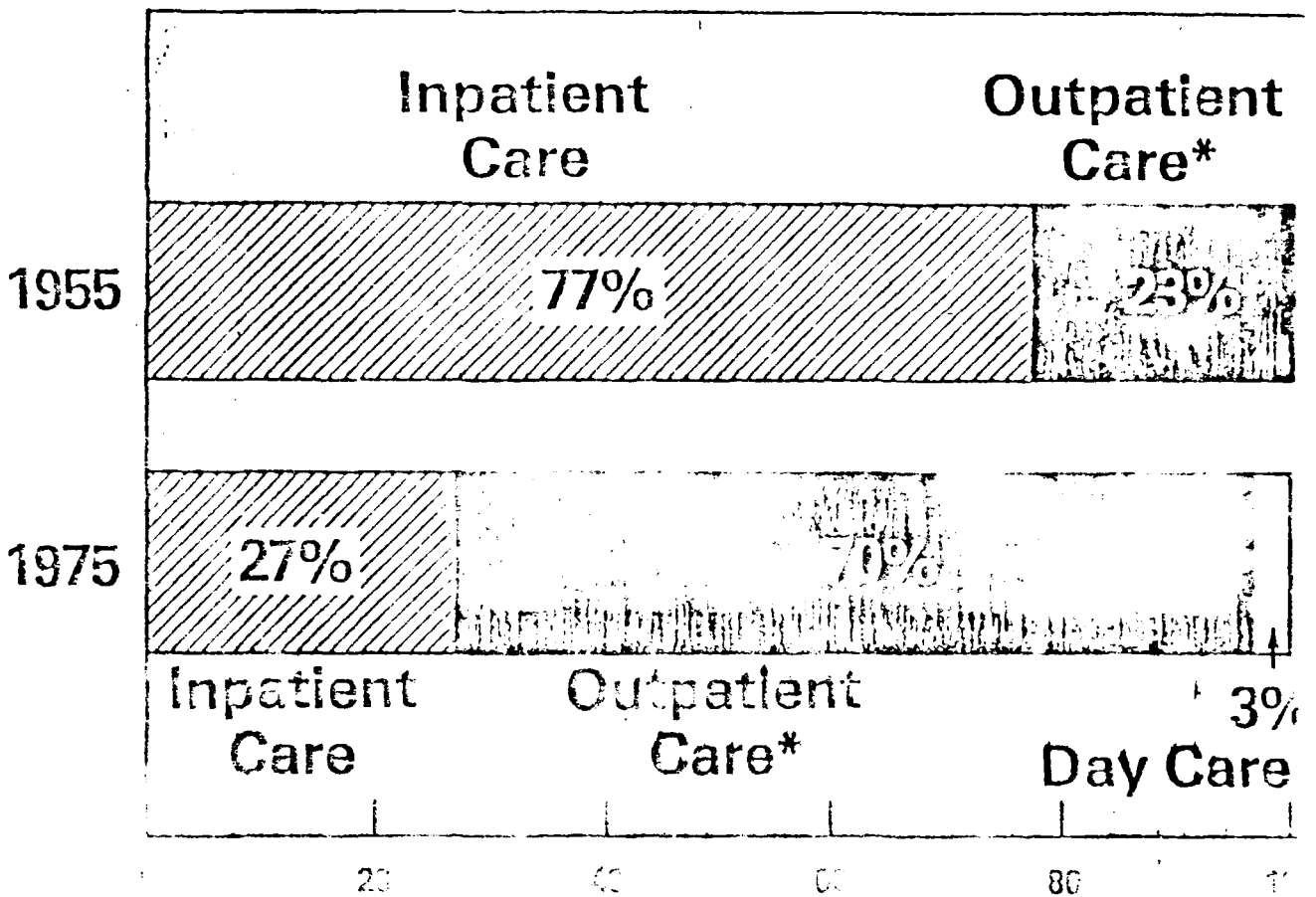
PSYCHIATRIC PATIENT-CARE EPISODE PER 100,000 POPULATION



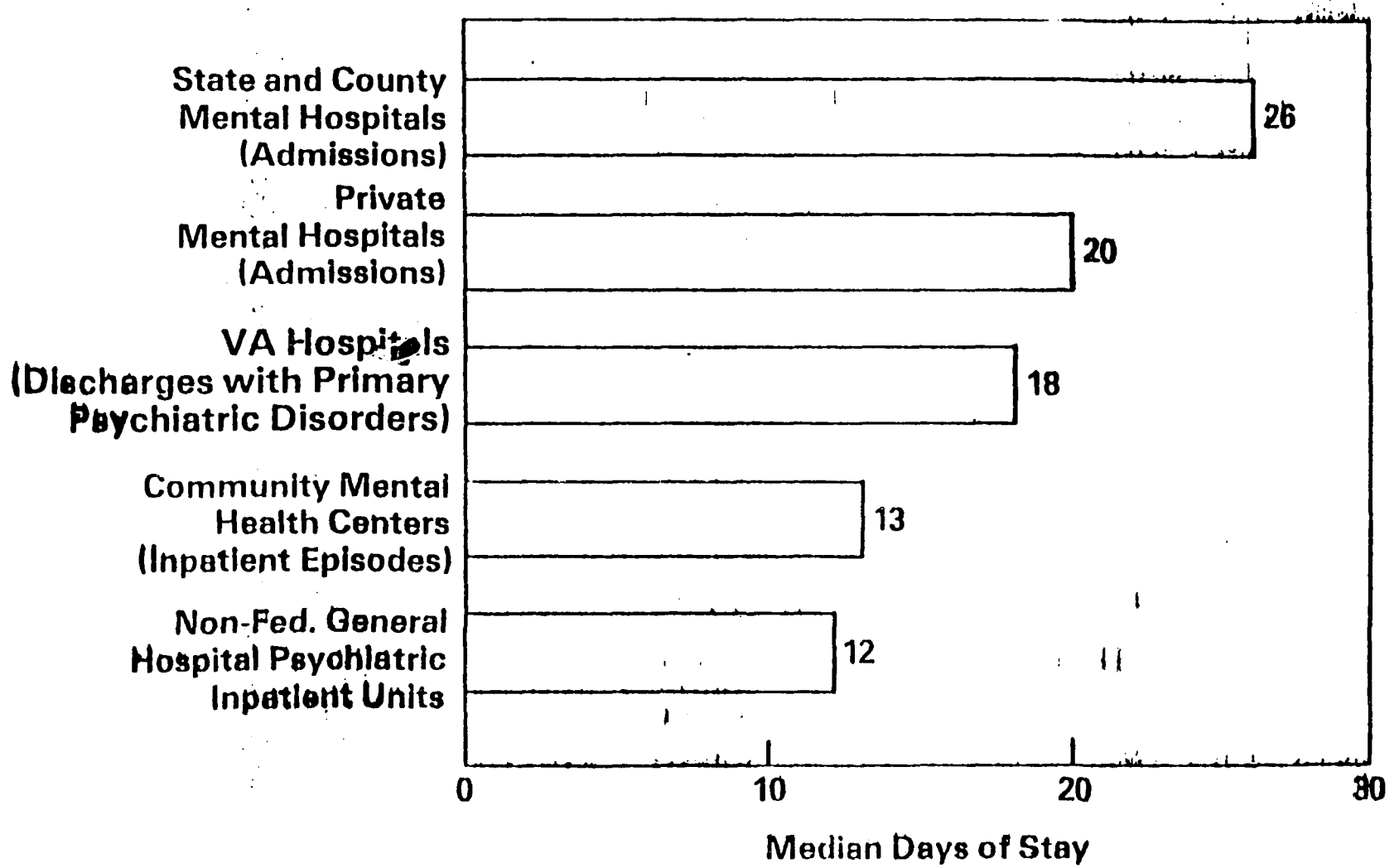
NUMBER OF RESIDENT PATIENTS AT YEAR-END IN STATE AND COUNTY MENTAL HOSPITALS



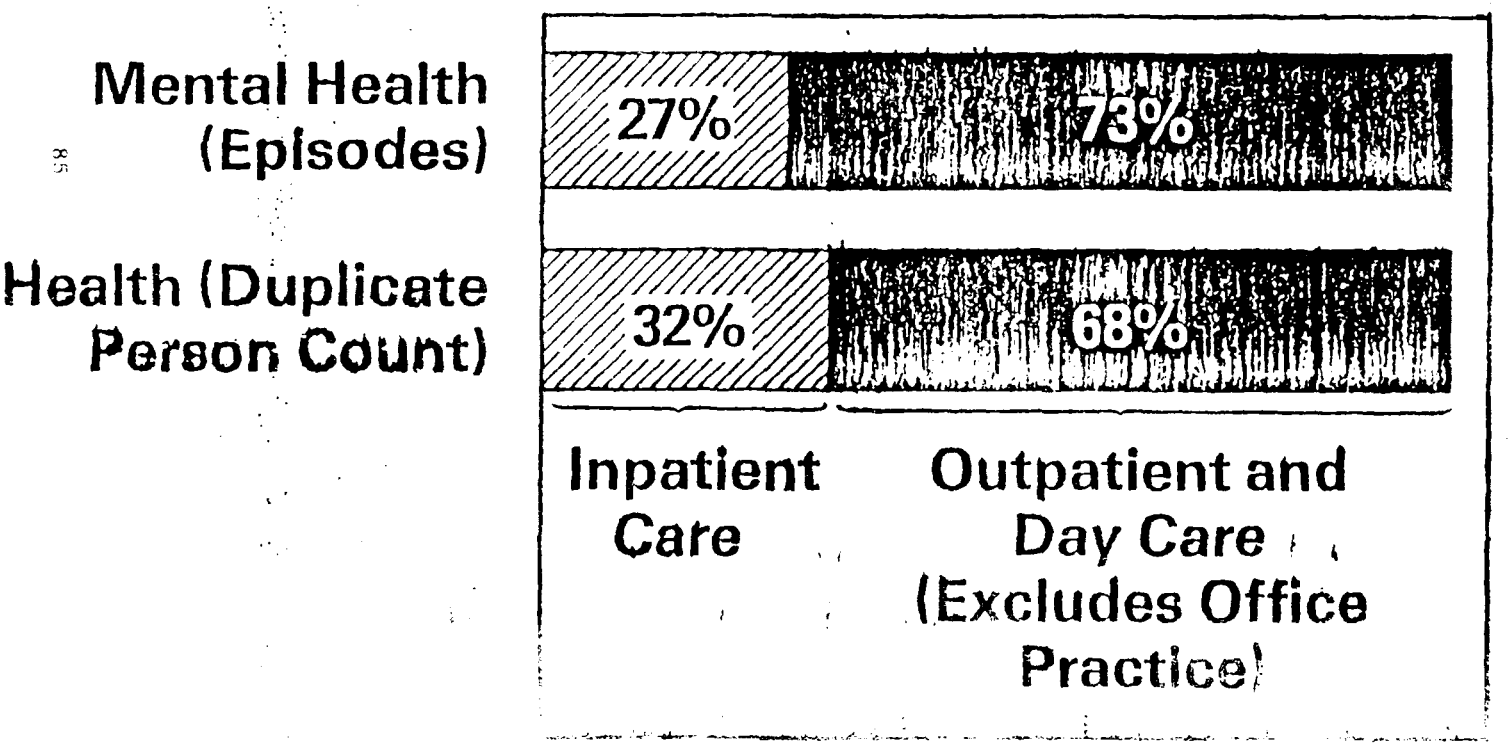
PERCENT DISTRIBUTION OF PATIENT CARE EPISODES IN MENTAL HEALTH FACILITIES, BY MODALITY U.S. — 1955, 1975



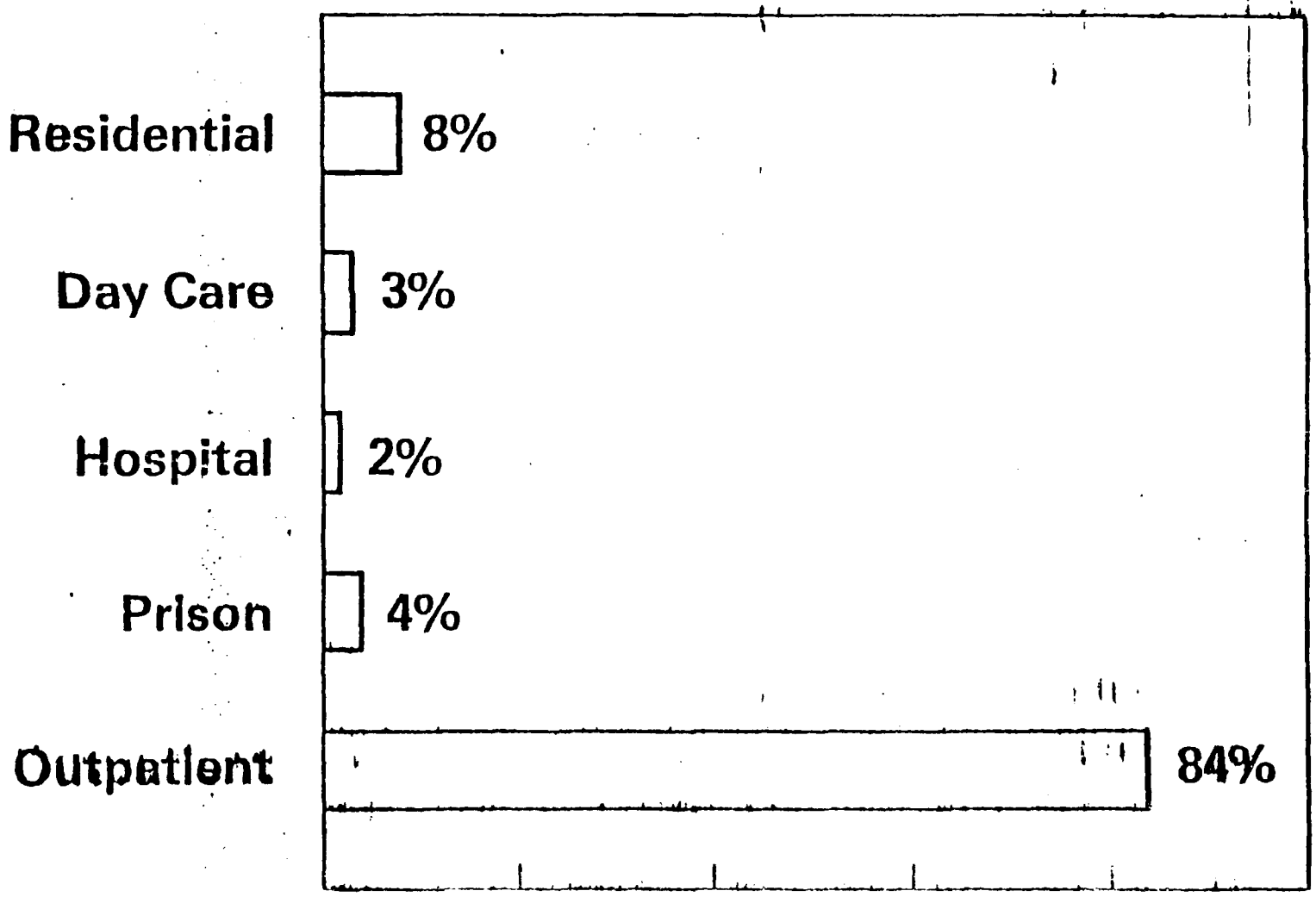
LENGTH OF STAY IN MENTAL HEALTH INPATIENT SETTINGS (1975)



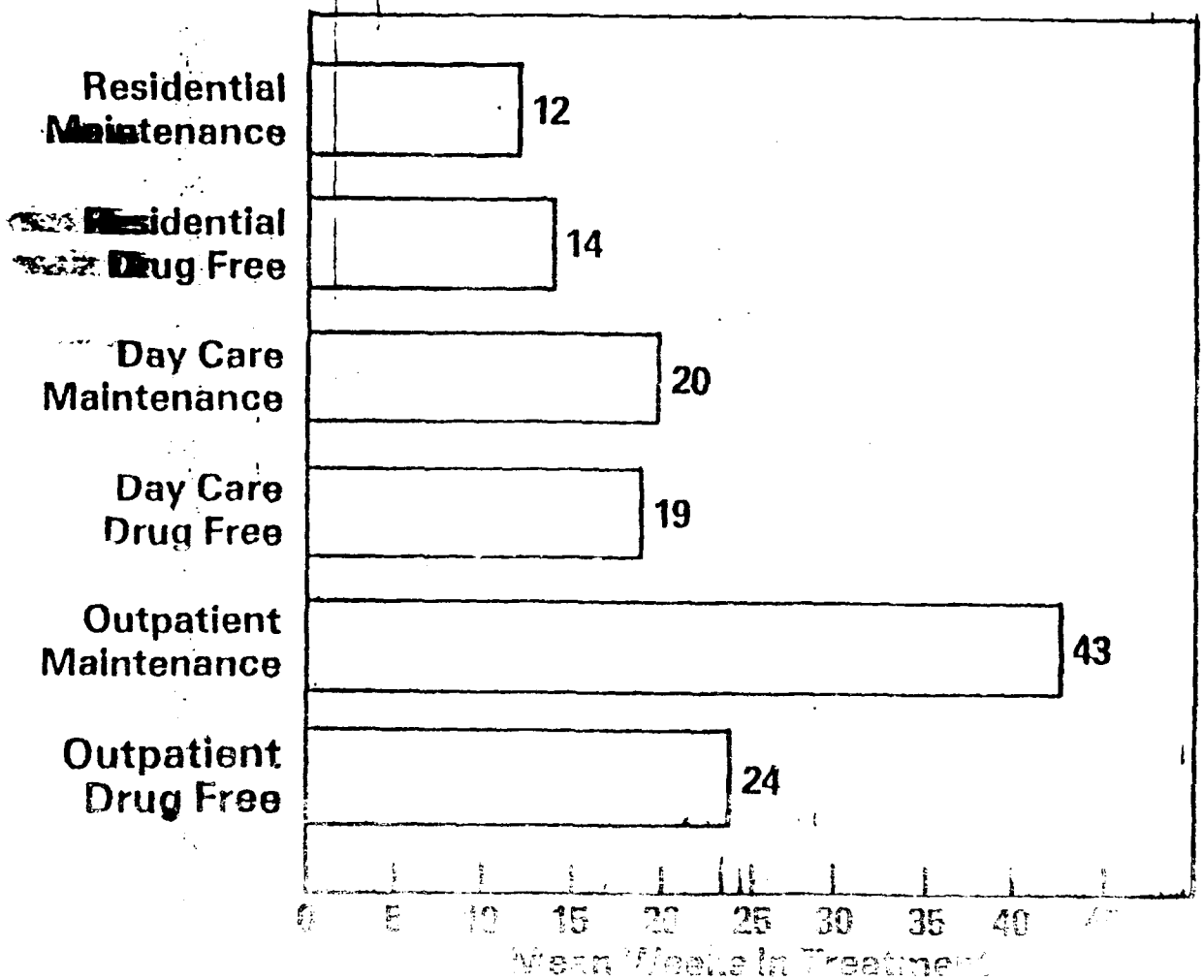
DIFFERENTIAL USE OF INPATIENT AND OUTPATIENT CARE, HEALTH (1973) AND MENTAL HEALTH (1975)



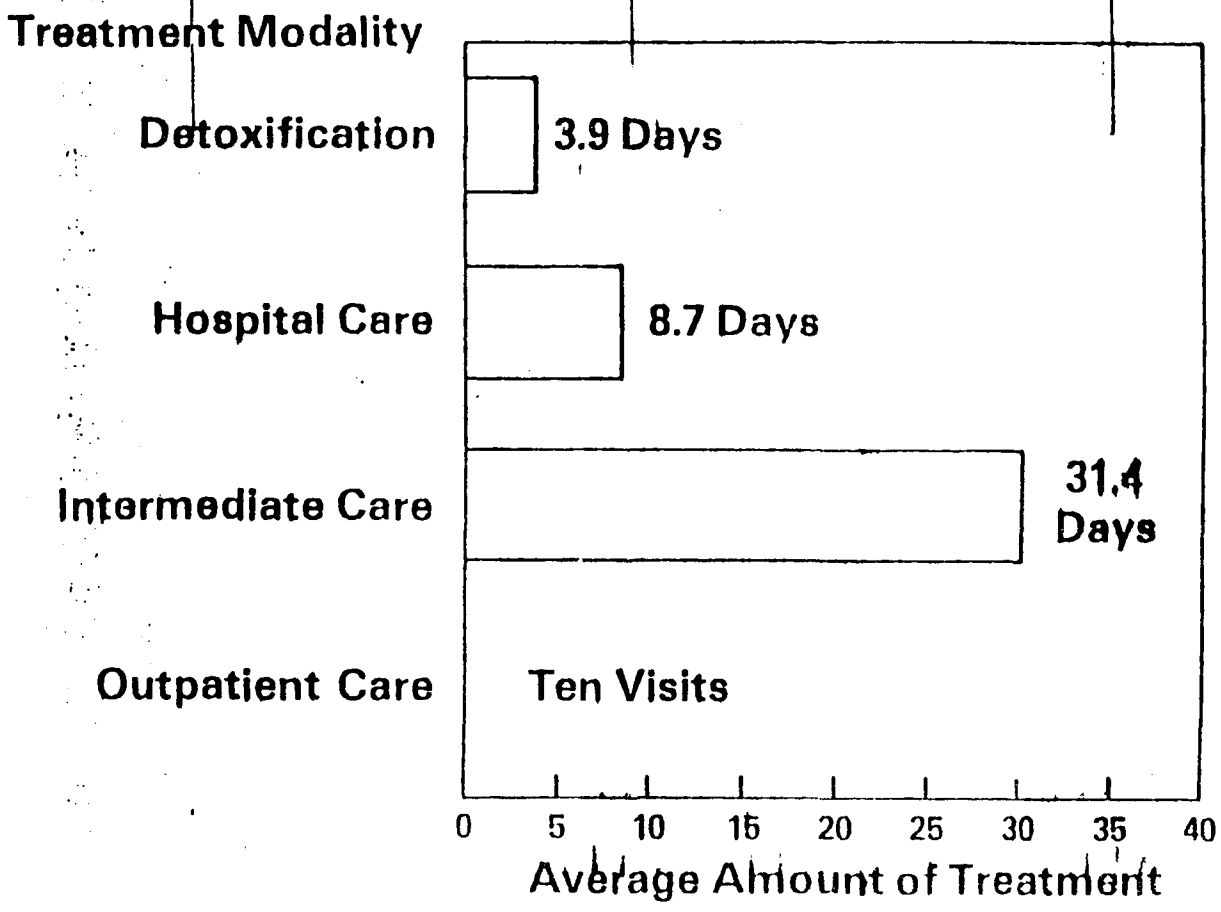
CLIENTS IN DRUG ABUSE TREATMENT, BY ENVIRONMENT APRIL, 1977 (N = 235,000)



LENGTH OF DRUG ABUSE TREATMENT BY TREATMENT MODALITY/ENVIRONMENT*

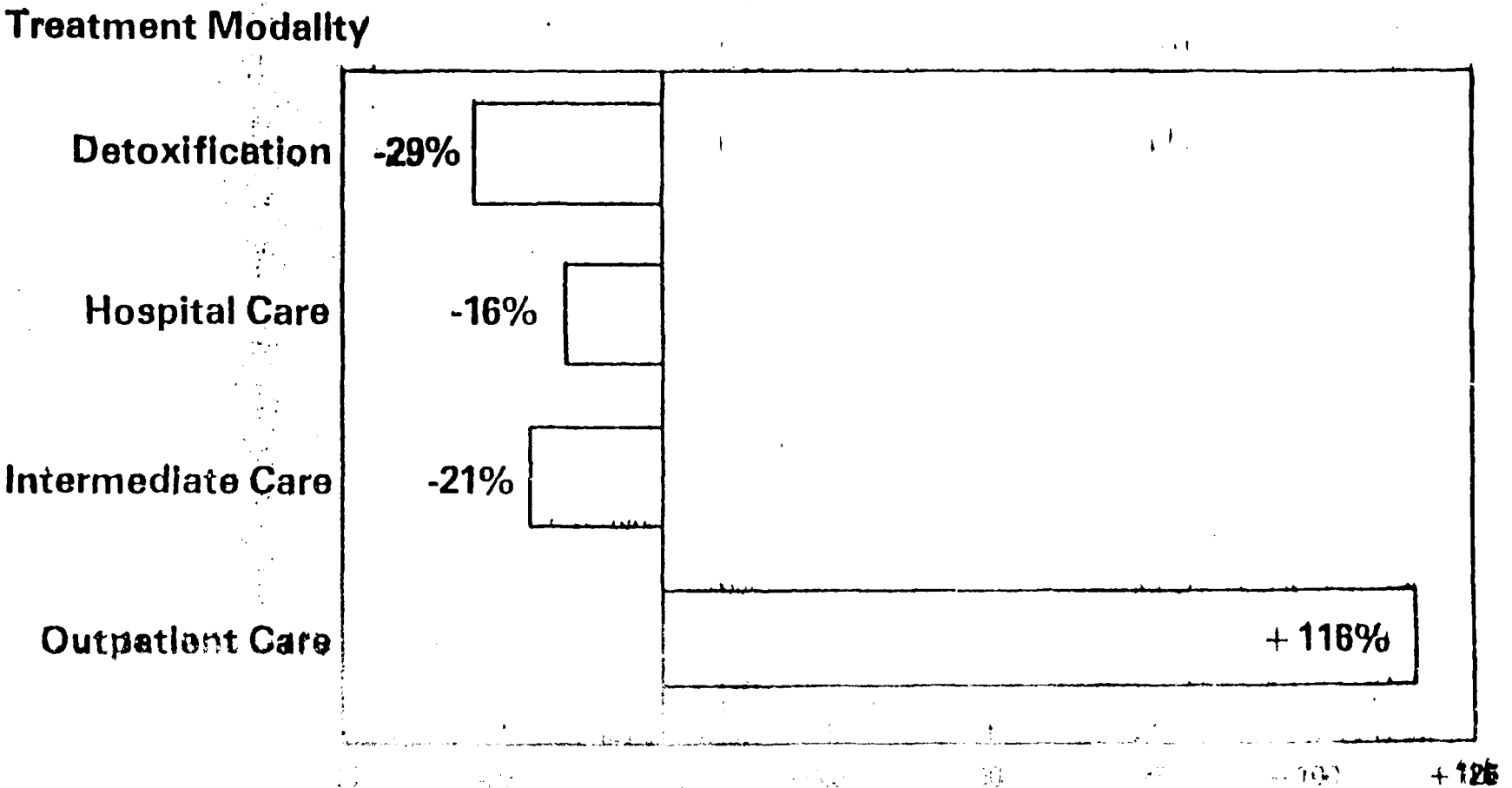


ALCOHOLISM
Average Length of Stay in Treatment in Alcoholism Treatment Centers By Modality in 1976



Avg. total length of stay was 2.5 months

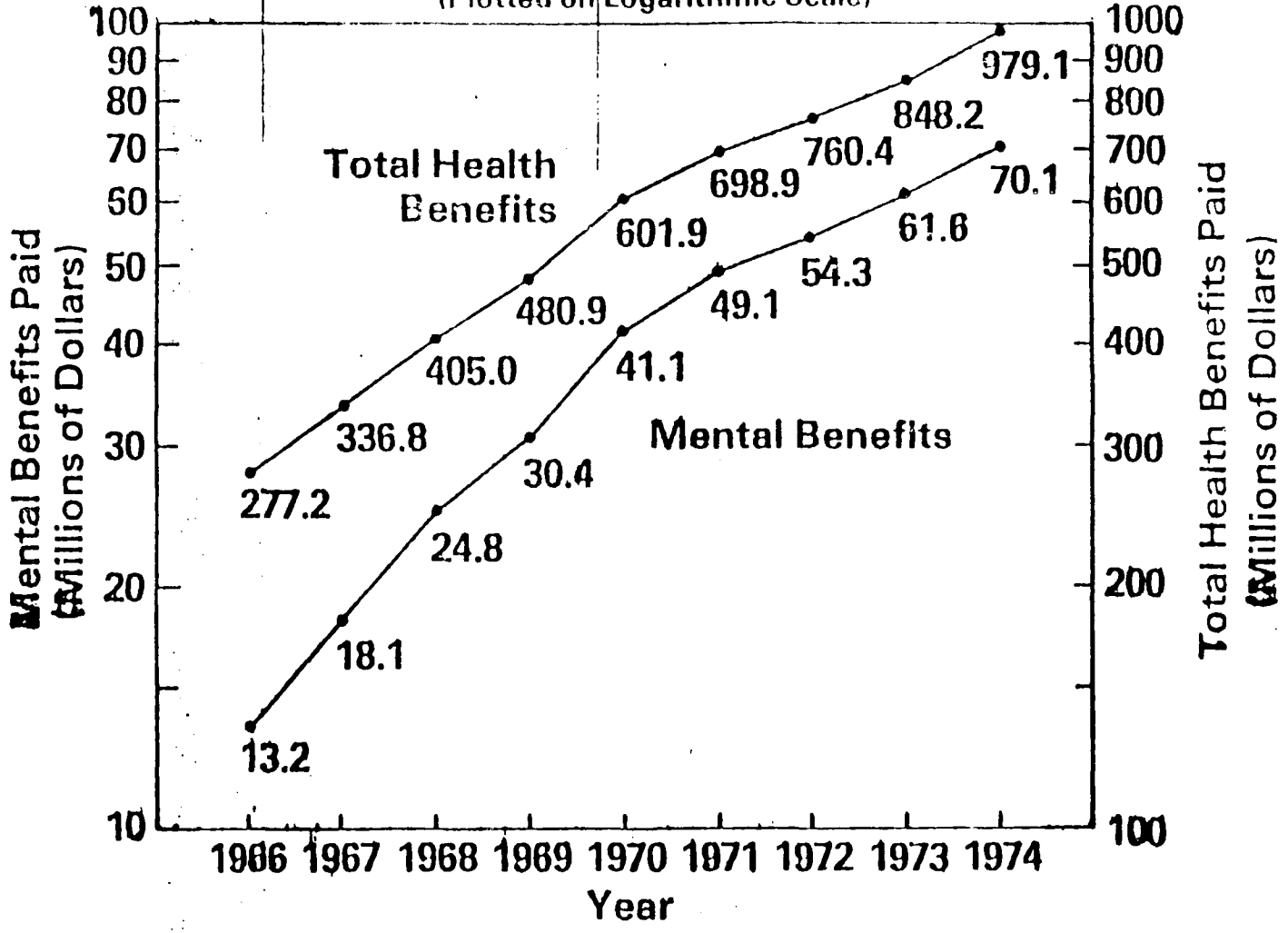
ALCOHOLISM
Percent Change in Modalities of Care in Alcoholism Treatment Centers 1973 — 1976



MENTAL AND NERVOUS BENEFITS AND TOTAL HEALTH BENEFITS PAID FOR ALL COVERED PERSONS, UNITED STATES, BY YEAR, 1966-1974

Federal Employee Health Benefit Program
Blue Cross and Blue Shield

(Plotted on Logarithmic Scale)



SOURCE: Office of the Actuary, U.S. Civil Service Commission.

REDUCED MEDICAL CARE EXPENDITURES AS AN OFFSET TO THE COST OF MENTAL HEALTH TREATMENT

Changes In Medical Care Utilization Following Therapy

Study	Hospital Days	Outpatient Visits	Physician Services	Medical Visits	Lab. & X-Ray Services	Total Medical Expenditures
1. West Germany	-85%					
2. Kaiser Permanente	-67%	-54%				
3. HIP			-8%		-15%	
4. GHA			-31%		-30%	
5. Kaiser of Oregon				-11%		
6. Puget Sound		-50%				
7. Blue Cross of Western Penn.						-31%
8. New York HIP (Medicaid Population)			-12%		-28%	
9. Mexican [illegible]						

REDUCED MEDICAL CARE EXPENDITURES AS AN OFFSET TO THE COST OF ALCOHOL TREATMENT

Changes In Medical Care Utilization Following Therapy

STUDY	SICKNESS ACCIDENT BENEFITS	HEALTH CARE COSTS
1. Oldsmobile	-33%	
2. ATC		Reduction of 46¢ in Health Care Costs* for each $1 spent
3. General Motors of Canada	-48%	
4. California Pilot Study		Reduction of 41¢ in Health Care Costs* for each $1 spent
5. Kennecott	-55%	
6. Illinois Bell Telephone Co.	-46%	
7. Phila. Fire Dept.	-55%	

*For the first year after alcoholism treatment

AD-A087 842 FITZSIMONS ARMY MEDICAL CENTER DENVER COLO F/G 5/10
BEHAVIORAL SCIENCES IN A CHANGING ARMY: PROCEEDINGS OF ARMY MED--ETC(U)
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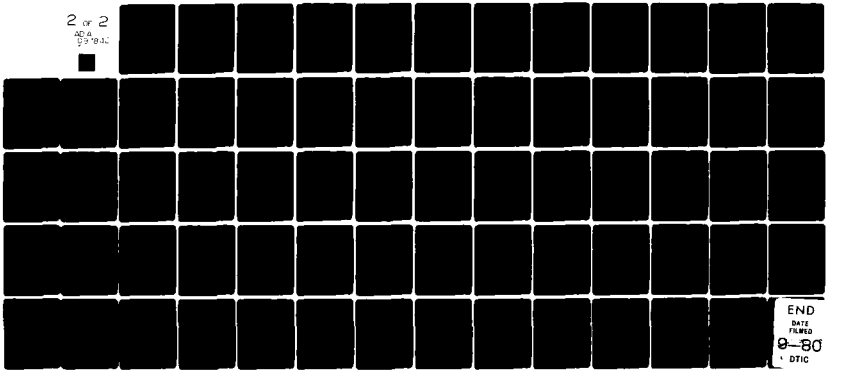

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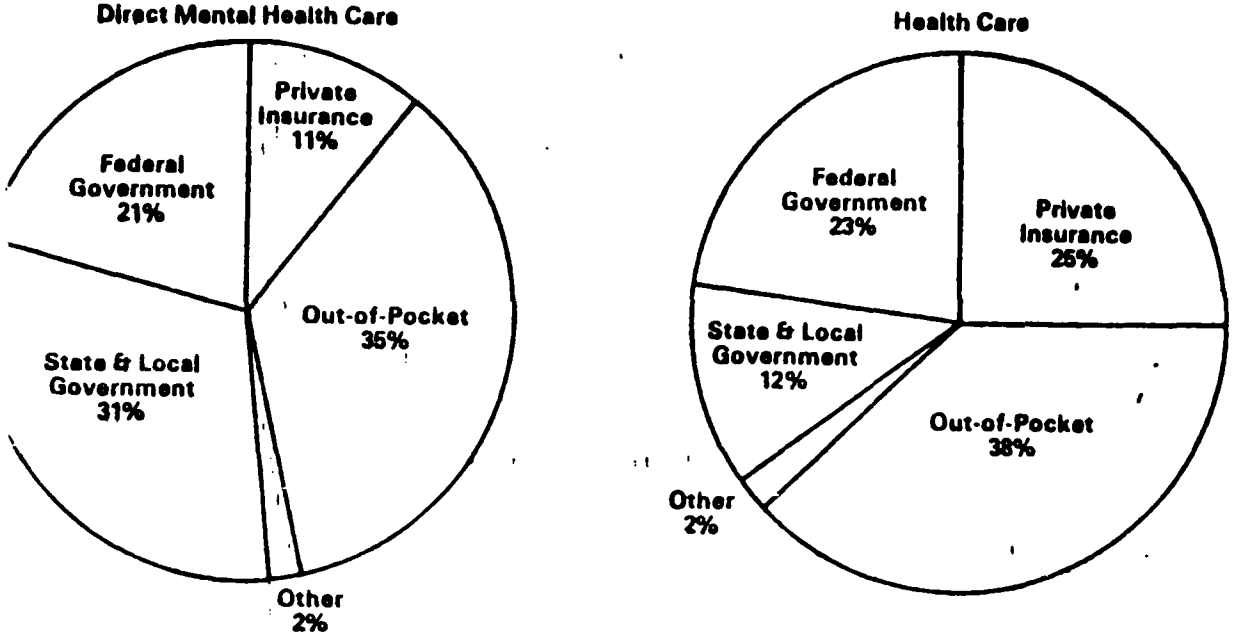
SOURCES OF FUNDS



SOURCES: Mental Health Statistics Series B, No. 7, Division of Biometry and Epidemiology, National Institute of Mental Health
Social Security Bulletin, Vol. 40, No. 4, Division of Health Insurance Studies, Social Security Administration

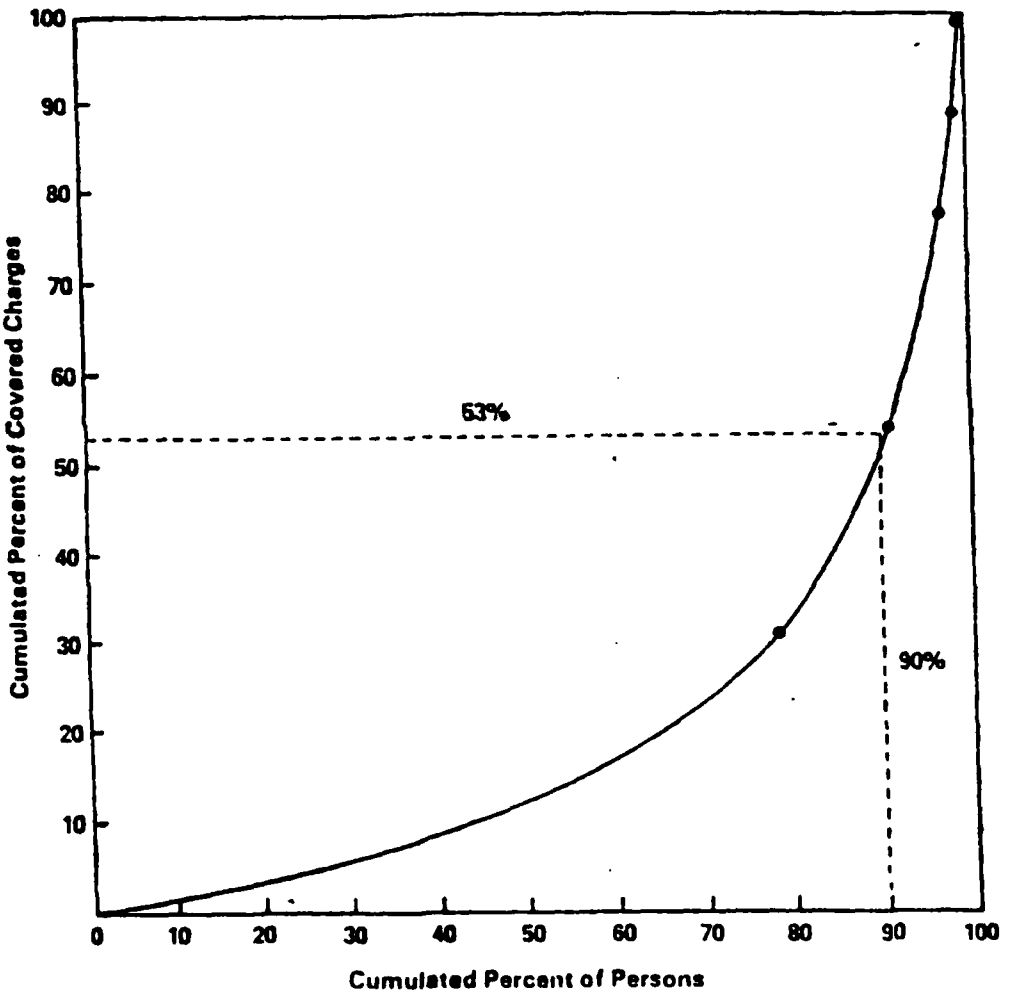
FUNDING PATTERNS FOR MENTAL HEALTH—HEAVY DEPENDENCE ON GOVERNMENT FUNDS—REFLECT HISTORICAL TREATMENT PATTERNS. WHILE CHANGES IN FUNDING PATTERNS HAVE OCCURRED, THEY HAVE NOT KEPT UP WITH THE CHANGES IN TREATMENT PATTERNS OVER THE PAST 20 YEARS WHICH NOW MORE CLOSELY APPROXIMATE THOSE OF THE GENERAL HEALTH CARE SYSTEM.

FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM
BLUE CROSS AND BLUE SHIELD: HIGH OPTION

PERSONS WITH COVERED PHYSICIAN CHARGES FOR OUTPATIENT CARE OF MENTAL DISORDERS UNDER SUPPLEMENTAL BENEFITS:

PERCENT OF COVERED PERSONS ACCOUNTING FOR INDICATED PERCENT OF ALL SUCH CHARGES, UNITED STATES, 1973

(Percent of persons cumulated from those with lowest to highest expenses)



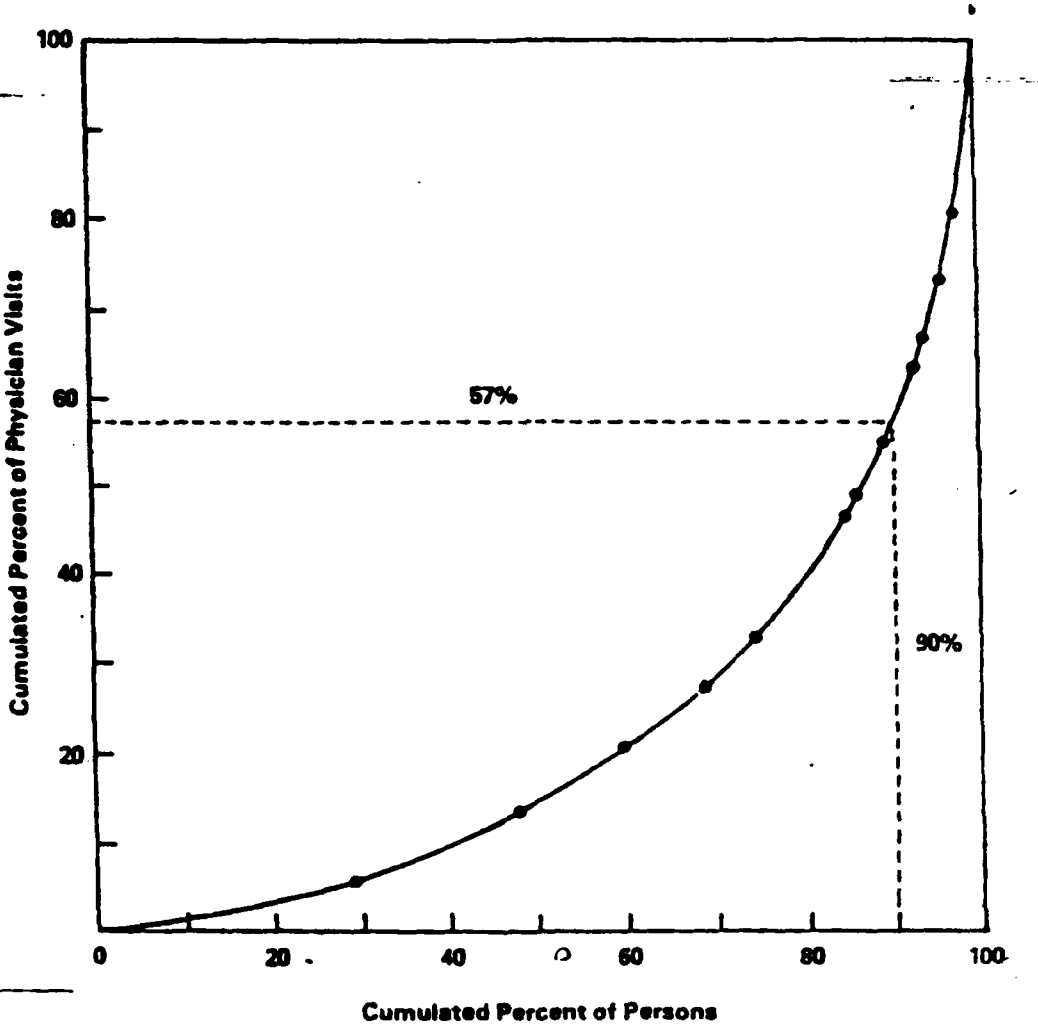
[illegible] Federal Employee Health Benefit Program

IN MENTAL HEALTH AS IN HEALTH, HIGH UTILIZERS REPRESENT A SMALL PERCENT OF PERSONS USING SERVICES:

- 10% ACCOUNT FOR 47% OF OUTPATIENT CHARGES FOR MENTAL HEALTH SERVICES
- 10% ACCOUNT FOR 37% OF INPATIENT CHARGES FOR MENTAL HEALTH SERVICES

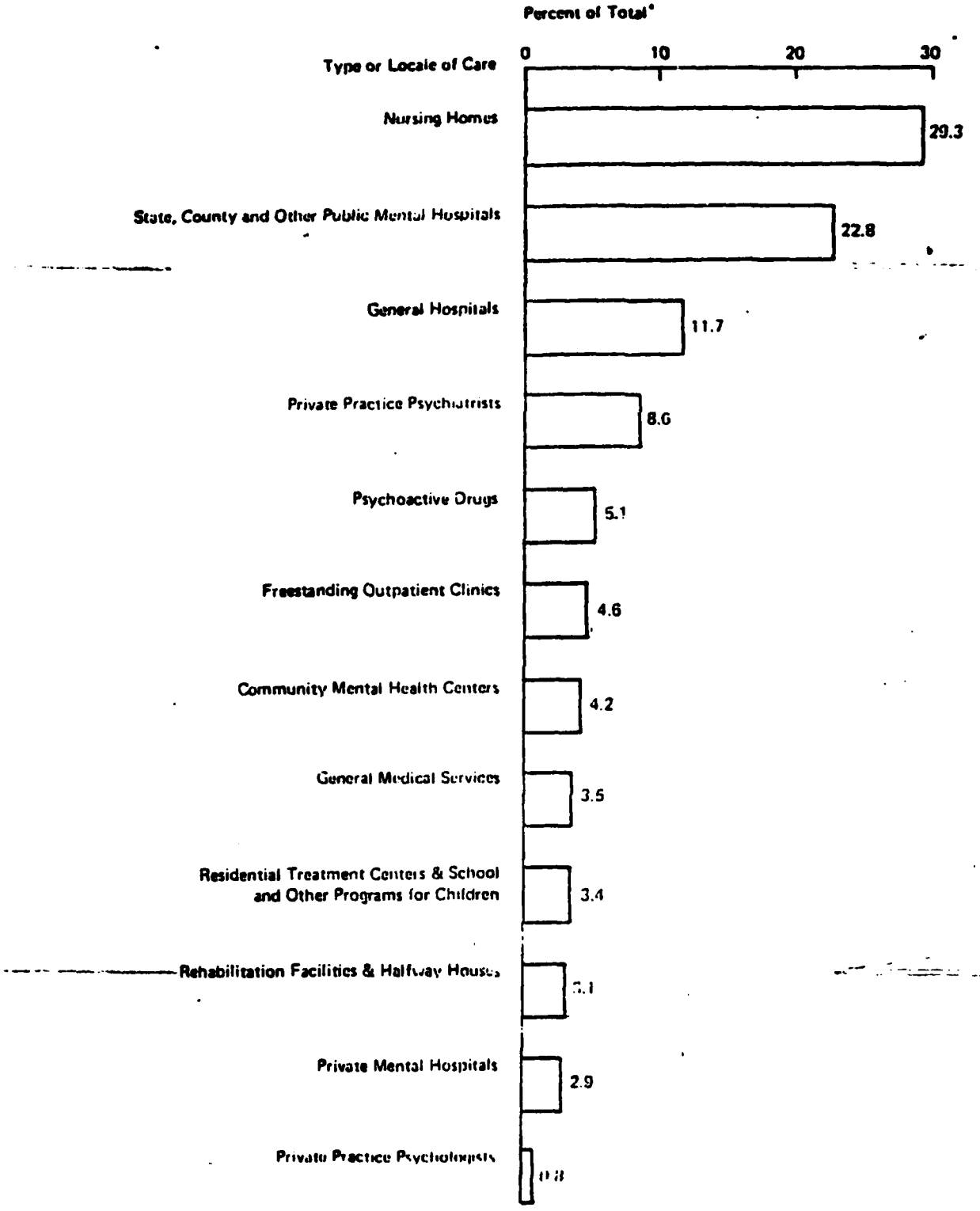
Chart 5

PERCENT OF PERSONS ACCOUNTING FOR PERCENT OF ALL PHYSICIAN VISITS, UNITED STATES, 1971



SOURCE: Physician Visits—Volume and Interval Since Last Visit—United States—1971, U.S. Department of Health, Education and Welfare, Public Health Service, Health Resource Administration

by Type or Locale of Care, United States, 1974



*Estimated total expenditures for direct care were $14.5 billion

Source: Statistical Note No. 125, Division of Biometry and Epidemiology, National Institute of Mental Health

A-4

Inclosure 3

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

.LTH AFFAIRS

JAN 26 1979

Donald W. Hammersley, M.D.
Deputy Medical Director
American Psychiatric Association
1700 Eighteenth Street, N.W.
Washington, D.C. 20009

Dear Dr. Hammersley:

While it is all still fresh in my mind, I thought I would try to set down on paper a distillation of our position as it was put forth during our meeting this past Friday. It will not be all inclusive but should contain the major points. Before I settle into the task at hand, I do want to say that I enjoyed meeting with you, Drs. McMahon and Kehne and Mr. Cutler. I also appreciate the restrained presentation on the speakers' parts of what are obviously strongly held points of view.

In considering our general approaches to the subject of confidentiality, I would characterize our respective positions as the pragmatic vs the ideal; public responsibility vs personal and professional; the likely vs the unlikely; conditional guarantees as opposed to absolute guarantees; and interdependence and accountability vs autonomy.

At the outset, a very basic question needs to be addressed - Why does any review have to be carried out? The need arises out of several factors: Abuse and overutilization of benefits occurs as a result of carelessness, perverse incentives in the system, and deliberate fraud. Malpractice occurs as a result of ignorance, illness, drug and alcohol abuse and failure to apply knowledge. These observations have been made repeatedly in and out of our CHAMPUS system, as well as in other Federal and private systems. The various health professions have shown scant inherent inclination to police themselves. Legislative and judicial fiat are not the best ways to control medicine's abuses and problems. Therefore, some form of internal regulation and self-policing, even though prompted by outside pressure, seems the best available approach. Finally, since the Government pays a substantial share of the bill for CHAMPUS mental health care, the Government has become a third member in the doctor-patient relationship. As operators of the CHAMPUS

Program, we are stewards of the public's money devoted to this cause. To exercise this stewardship we need to know what is happening, and to do this we need information. It is at this point that our requirement for knowledge conflicts with the doctor's and patient's desire for privacy and anonymity. We are responsible for seeing that the public's funds are well and wisely spent.

However, this is not our only responsibility; we must also operate a claims-payment operation, which brings the fiscal intermediary into the picture. While the patient may be concerned about lack of privacy, he becomes absolutely irate, and justifiably so, if claims aren't paid promptly. Doctors are very good at getting irate, as well. In order to make this aspect of the system work as well as possible, decision authority is delegated downward to the maximum extent possible. Using carefully designed guidelines, such as those professionally developed by the APA, the second level reviewer has limited latitude to deny claims and wide latitude to authorize payment. An appeals system exists to handle complaints about improper termination of benefits. Needless to say, no one has ever appealed the payment of a claim. The third level reviewer, the physician, acts as a final arbiter in the process and to check long-term cases where the Government has a particularly large financial stake. Third level retrospective review, like concurrent review, is, in itself, an expensive and time-consuming practice. The number of people who have legitimate routine access to the information gathered in and required for this process is very limited, particularly detailed, clinical data. As I mentioned during the meeting, the clinical data is not computerized. The records are not only essential to claims processing but also allow us to audit and follow the performance of each step of the process, including the third level reviewers. There are others to whom we have to answer for the effectiveness and efficiency of this review process.

While the process just described is not perfect and will no doubt be improved with experience, it does offer one very great advantage - it provides reasonable access to care on a rational basis of need. The matter of access highlights one of the most basic differences between military and civilian medical practice. The private practitioner has responsibility only to the individual patient or patients that he chooses to see, while the military system has a responsibility for the medical care of every one of its beneficiaries. The exercise of that responsibility demands that the available care be parceled out as effectively and equitably as possible. This is the flip side of cost control, the wise distribution of available benefits.

I believe the above discussion clearly justifies our peer review activities. We hope to do them well, and the APA's assistance in the field of psychiatry has been of great benefit to us and to psychiatry. The derivation of criteria that will work effectively for the patient in our system has been a difficult process, I know. Personally, I feel it is very important that psychiatry set down in some rigorous way precisely what it does and how it does it, thereby joining the mainstream of American medicine. What we are doing in the APA contract is admittedly experimental and is on the cutting edge of peer review activities in psychiatry. We have high hopes for it. Should we fail, I believe the specter of elimination of benefits or the imposition of arbitrary treatment limits may take on real substance.

As I stated at the outset of the meeting, there is no way to absolutely guarantee that the confidentiality of clinical information will not be breached at some time; however, I am reassured that it hasn't happened yet, to our knowledge, in the history of the program. This argues that the present system works. In the absence of any proof that it doesn't work, there is no reason to change or establish new policy on confidentiality in anticipation of a very unlikely event, an event which is in the last analysis, unpreventable. We will, however, investigate our existing procedures and do what we can to protect sensitive clinical information to the maximum.

Finally, I must acknowledge that I felt there was an unspoken item on the agenda last Friday and that is the physician's dislike, if not abhorence, of Governmental "interference" in the private practice of medicine or, in this case, psychiatry. This is understandable. Like it or not, however, medicine is changing; and the minute public funds are used and accepted, then it is no longer a totally private affair, as it was in times past; and the Government's participation is inevitable. The price for what autonomy remains is proven accountability and responsible performance.

I hope this is a fair summation of our position. Again, it was a pleasure meeting with you and I hope that the meeting served to help resolve concerns about confidentiality.

Sincerely,

Peter A. Flynn
Captain, MC, USN
Acting Deputy Assistant Secretary of Defense
(Health Resources and Programs)

cc: Dr. Sabshin

MDA906-77-C-0030

SECTION F - SCOPE OF WORK

F-1. STATEMENT OF TASKS

a. TASK I - IDENTIFY REVIEWERS

Using CHAMPUS workload experience, the CHAMPUS Contracting Officer's Technical Representative (COTR), and the APA's prior experience in the review of psychiatric cases the American Psychiatric Association (APA) is being asked to:

(1) Using mutually agreeable criteria, identify and maintain during the contract life, an adequate number of psychiatrists willing to participate as CHAMPUS third level Psychiatric Review Committees (PRC) in the CHAMPUS Psychiatric Review Systems. The geographic area where reviewers will be required includes the continental United States, Alaska, Puerto Rico, and Hawaii.

(2) Arrange through the COTR the establishment of the CHAMPUS PRC - CHAMPUS Fiscal Intermediary relationship for the areas described in subparagraph 1.

b. TASK II - PROVIDE EDUCATIONAL PROGRAM

Using the COTR as a technical resource, provide an educational program designed to explain the responsibilities of the PRC members, provide background to the PRC members about the project and the CHAMPUS program, and update the PRC members on the progress of the project. Meetings to provide this educational program shall be coordinated with the COTR who shall have the option to participate. Advance notification shall be provided to the COTR no later than 15 work-days prior to the meeting date.

c. TASK III - TRAIN SECOND LEVEL REVIEWERS

Provide professional expertise in the training of CHAMPUS Claims Processors' second level reviewers (usually nurses) to appropriately handle psychiatric claims and case reviews. Arrangements for bringing the appropriate individuals together will be arranged by OCHAMPUS.

d. TASK IV - PROVIDE THIRD LEVEL REVIEW

The Contractor is being asked to provide the third level review of all inpatient mental health benefits reimbursed by CHAMPUS and all out-patient services provided by psychiatrists through the PRCs identified in TASK I. Payment for the committee members' services is to be provided by the APA with dollars provided through this contract. Monitoring of the PRC's performance is the responsibility of the APA. Close coordination of this task with the COTR is to be established by means to be determined jointly. The COTR is responsible for monitoring the APA's performance of

this task. A team of three psychiatrists will comprise a Psychiatric Revie. Committee (PRC) and will review each case determined to require third level review. The PRC will relate with the CHAMPUS Fiscal Intermediary for the geographic area in which the PRC is reviewing, and be reimbursed by the APA with dollars provided through this contract. The criteria used to determine which cases go to third level review will be CHAMPUS Regulation 6010.8-R and instructions to Fiscal Intermediaries drawn by OCHAMPUS and based on criteria developed by the APA and other sources.

e. TASK V - PROVIDE A NATIONAL PANEL

Provide a panel of psychiatrists, one of whom is the Chairperson, to serve as a National Advisory Panel to OCHAMPUS in carrying out the building of this review system. In addition to overseeing the general operations of this project, the panel is also being requested to:

(1) Formulate recommendations pertaining to the project to be provided to OCHAMPUS.

(2) Serve as a resource to help OCHAMPUS in those exceptional psychiatric cases requiring third level review throughout the contract life.

(3) Upon request by OCHAMPUS, assist OCHAMPUS in providing educational services to Fiscal Intermediaries' staff and/or assist Fiscal Intermediaries and OCHAMPUS in resolving problems as they occur.

f. TASK VI - DEVELOP CRITERIA FOR INPATIENT/OUTPATIENT CARE

The Contractor is to provide the following regarding the review of in-patient/outpatient psychiatric cases:

(1) A set of criteria for each of the CHAMPUS flag points (8, 24, 40, 60 visits) by OCHAMPUS in the preparation of instructions to the CHAMPUS Fiscal Intermediaries' claims clerks to determine whether the claim should: (a) be processed for payment; (b) sent to the second level review; (c) sent to the third level review, or (d) rejected for payment.

(2) A set of criteria for each of the CHAMPUS flag points (8, 24, 40, 60 visits) by OCHAMPUS in the preparation of instructions to the CHAMPUS Fiscal Intermediaries' second level reviewers to determine whether the claim should: (a) be processed; (b) sent to third level review, or (c) rejected for payment.

(3) A list (or format for a form) which identifies and/or describes the information required of the provider to enable the decisions to be made described above. Included should be a description of the data/information required of the provider if the case is to go for third level review (CHAMPUS PRC).

(4) Periodic reviews and updating of the criteria sets to maintain their currency and appropriateness.

Reprinted from the Amer. J. Psychiatry, Sep 1973

A-6

OFFICIAL ACTIONS

The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry

This statement was approved by the Assembly of District Branches and the Board of Trustees of the American Psychiatric Association at their May 5-6, 1973, meetings, upon recommendation of the Committee on Ethics.[1]

FOREWORD

ALL PHYSICIANS should practice in accordance with the medical code of ethics set forth in the Principles of Medical Ethics of the American Medical Association. An up-to-date expression and elaboration of these statements is found in the *Opinions and Reports of the Judicial Council* of the American Medical Association (1). Psychiatrists are strongly advised to be familiar with these documents.[2]

However, these general guidelines have sometimes been difficult to interpret for psychiatry, so further annotations to the basic principles are offered in this document. While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice, even though the basic principles are the same. The annotations are not designed as absolutes and will be revised from time to time so as to be applicable to current practices and problems. Although the material appears in this form for the first time, it is derived from the work of many committees and task forces over the years.

Following are the AMA Principles of Medical Ethics, printed in their entirety, and then each principle printed separately along with an annotation especially applicable to psychiatry.

[1] The committee included C.H. Hardin Branch, M.D., Chairman, Herbert Klemmer, M.D., Robert A. Moore, M.D., Robert P. Nenno, M.D., Alex D. Pokorny, M.D., Charles D. Prudhomme, M.D., Joseph S. Skopha, M.D., and Gene Usdin, M.D. William P. Camp, M.D., and Byron A. Ellsbol, M.D., were members of the subcommittee that aided in the preparation of these annotations, and William A. Bellamy, M.D., was special consultant.

[2] Chapter 8, Section 1 of the By-Laws of the American Psychiatric Association states: "All members of the American Psychiatric Association shall be bound by the ethical code of the medical profession especially defined in the Principles of Medical Ethics of the American Medical Association."

PRINCIPLES OF MEDICAL ETHICS, AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1

The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3

A physician should practice a method of healing founded on a scientific basis, and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient.

SECTION 8

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10

The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.[1]

SECTION 1

The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

The patient may place his trust in his psychiatrist knowing that the psychiatrist's ethics and professional responsibilities preclude him from gratifying his own needs by exploiting the patient. This becomes particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.

The requirement that the physician "conduct himself with propriety in his profession and in all the actions of his life" is especially important in the case of the psychiatrist because the patient tends to model his behavior after that of his therapist by identification. Further, the necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control. Sexual activity with a patient is unethical.

The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.

Physicians generally agree that the doctor-patient relationship is such a vital factor in effective treatment of the patient that preservation of optimal conditions for development of a sound working relationship between a doctor and his patient should take precedence over all other considerations. Professional courtesy may lead to poor psychiatric care for physicians and their families because of embarrassment over the lack of a complete give-and-take contract.

SECTION 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.

SECTION 3

A physician should practice a method of healing founded on a scientific basis and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

It would seem self-evident that a psychiatrist who is a lawbreaker might be ethically unsuited to practice his profession. When such illegal activities bear directly upon his practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine.

A psychiatrist who regularly practices outside his area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.

Special consideration should be given to those psychiatrists who, because of mental illness, jeopardize the welfare of their patients and their own reputations and practices. It is ethical, even encouraged, for another psychiatrist to intercede in such situations.

SECTION 5

A physician may choose whom he will serve. In an

[1] Statements in italics are taken directly from the American Medical Association's Principles of Medical Ethics or annotations thereto (1).

emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him, and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, or socioeconomic status.

SECTION 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision, or individual whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, for a salary, or for a fixed rate per capita.

Contract practice per se is not unethical. Contract practice is unethical if it permits features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

The ethical question is not the contract itself but whether or not the physician is free of unnecessary nonmedical interference. The ultimate issue is his freedom to offer good quality medical care.

In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment.

When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if he allows himself to be used as a figurehead.

In the practice of his specialty, the psychiatrist consults, associates, collaborates, or integrates his work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health nurses, etc. Furthermore, the nature of modern psychiatric practice extends his contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, ag volunteers, and neighborhood aides. In referring patie for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he is dealing is a recognized member of his own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he refers patients. Whenever he has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him.

Also, he should neither lend the endorsement of the psychiatric specialty nor refer patients to persons, groups, or treatment programs with which he is not familiar, especially if their work is based only on dogma and authority and not on scientific validation and replication.

In accord with the requirements of law and accepted medical practice, it is ethical for a physician to submit his work to peer review and to the ultimate authority of the medical staff executive body and the hospital administration and its governing body.

SECTION 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

The psychiatrist may also receive income from administration, teaching, research, education, and consultation.

Charging for a missed appointment or for one not cancelled 24 hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration of the patient and his circumstances.[1]

Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement

[1] This paragraph is reprinted as an annotation to Section 7 of AMA's *Opinions and Reports of the Judicial Council* (1, p. 39).

between the patient and the treating physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.

It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of the specific contractual agreement with the patient.

SECTION 8

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of the medical service may be enhanced thereby.

The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve he may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.

SECTION 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he must be circumspect in the information that he chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the student's explicit permission.

Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.

The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his duty of confidentiality.

Ethically the psychiatrist may disclose only that information which is immediately relevant to a given situation. He should avoid offering speculation as fact. Sensitive information such as an individual's sexual orientation or fantasy material is usually unnecessary.

Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.

Psychiatrists at times may find it necessary, in order to protect the patient or the community from imminent danger, to reveal confidential information disclosed by the patient.

Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time the psychiatrist must assure the minor proper confidentiality.

When the psychiatrist is ordered by the court to reveal the confidences entrusted to him by patients he may comply or he may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment, should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.

SECTION 10

The honored ideals of the medical profession im-

ply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government. A psychiatrist should clarify whether he speaks as an individual or as a representative of an organization. Furthermore, psychiatrists should avoid clouding their public statements with the authority of the profession (e.g., "Psychiatrists know that. . .").

Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness. Psychiatrists should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine.

On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention, or who has disclosed information about himself through public media. It is unethical for a psychiatrist to offer a diagnosis unless he has conducted an examination and has been granted proper authorization for such a statement.

The psychiatrist should not permit his certification to be used for the involuntary commitment of any person except when this is clearly necessary for the patient's own protection or the protection of others from probable injury at the patient's hands.

"A complaint concerning the behavior of a member of this Association shall be in writing, signed by the complainant, and filed with the Secretary." (Chapter 10, Section 1, By-Laws, American Psychiatric Association.)

REFERENCE

1. Judicial Council, American Medical Association: Opinions and Reports of the Judicial Council. Chicago, AMA, 1971

A complaint concerning the behavior of a member of this Association shall be in writing, signed by the complainant, and filed with the Secretary. The Secretary shall refer it to the appropriate district branch for investigation and action. The Secretary shall notify the accused member that he has received such a complaint and has forwarded it to the member's local district branch, and shall inform the accused member of his right to appeal any forthcoming action to the Board of Trustees.

The district branch may appeal to the Board of Trustees for relief from responsibility for considering any complaint.

The complainant shall have the right of appeal to the Board for reconsideration of the decision of the district branch. (Chapter 10, Section 1, By-Laws, American Psychiatric Association, 1973 Revision)

A complaint, as noted above, must be written, must be signed by the complainant, and must be filed with the Secretary of the Association.

I. Secretary

A. Clarifies the complaint and relates it to violation of a specific section of the Principles of Medical Ethics with APA's Annotations Especially Applicable to Psychiatry.

B. Indicates the membership status of the defendant.

C. Refers it to the appropriate district branch for investigation and action.

D. Sends the material to the Ethics Committee for information.

E. Notifies the accused member that he has received a complaint and has forwarded it to the member's local district branch, informing the accused member of his right to appeal any forthcoming action to the Board of Trustees.

F. Notes that a charge has been filed and will be investigated by the assigned district branch.

G. Notes to the district branch the right of the complainant and the defendant to representation by counsel.

II. District Branch

A. Rejects the assignment and returns the complaint to Board of Trustees under certain circumstances (possible reasons: defendant is member-at-large or the nature of the complaint justifies a change of venue).

B. Investigates the complaint, permitting both the defendant and complainant to be heard, with representation by counsel if requested.

C. Determines:

1. The complaint to be without merit and recommends that it be dismissed

2. That the complaint has been sustained and the defendant is found:

(a) Not guilty

(b) Guilty, with the following alternatives:

(1) Admonishment

(2) Reprimand

(3) Suspension from membership for a specific period of time

(4) Expulsion from the district branch

D. Notifies the Board of Trustees, which:

1. Sends information to the national Ethics Committee

2. Takes action on recommendations of the district branch

3. Notifies the complainant and the defendant of the actions taken

III. National Ethics Committee

If the case is sent by the Board of Trustees to the national Ethics Committee it may, in investigating a complaint, designate two Fellows not on the committee to serve as investigators. Any member under investigation shall be entitled to 30 days' notice in writing, advising him of the charges, and the date and place of the hearing before the Ethics Committee. He shall have the right to personal appearance and determination. The final action taken by the Ethics Committee is a recommendation to the Board of Trustees. The Board of Trustees will then inform the district branch of its action so that the appropriate parallel action may be taken.

The committee may:

A. Determine that the complaint is without merit and recommend that it be dismissed.

B. Advise the Board that a complaint has been sustained and recommend that the member be admonished, reprimanded, suspended from membership for a specific period of time, or expelled from the Association.

The Board of Trustees informs the district branch of its action so that an appropriate parallel action may be taken.

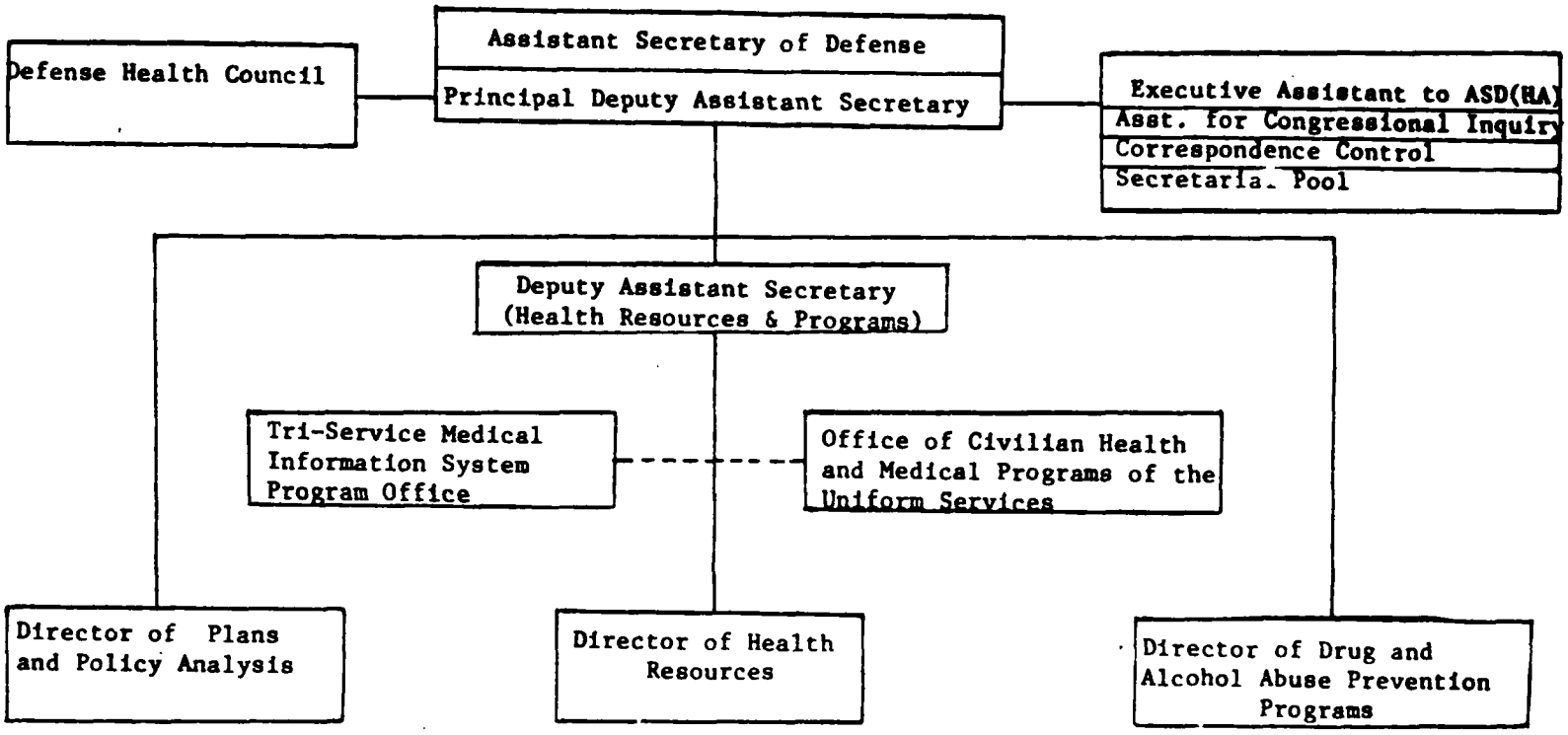
IV. Appeal Procedure

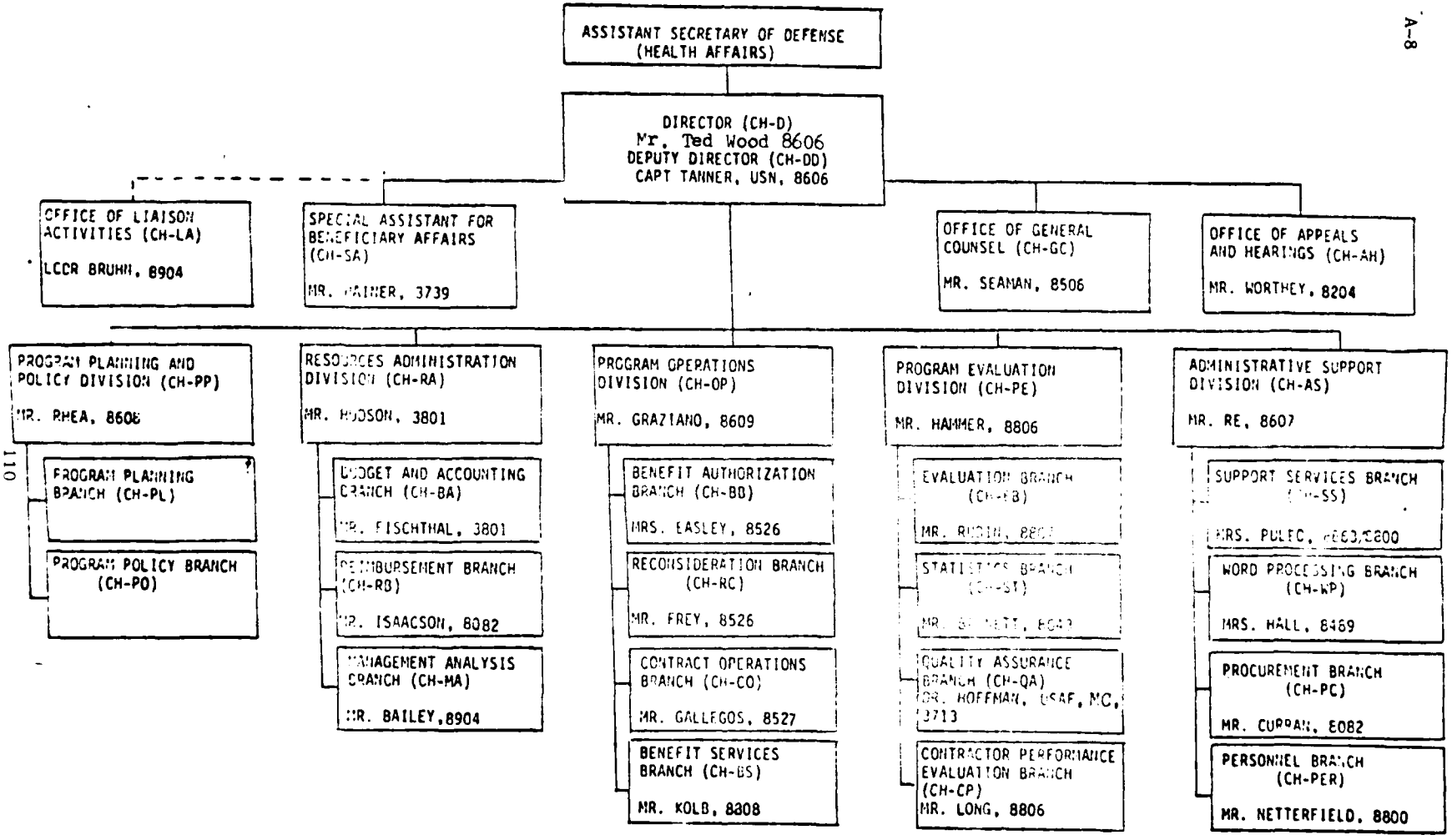
A disciplined member may appeal to the membership by filing a notice of such intent with the Secretary within 30 days after notification of the action of the Board. Expelled members shall be denied all membership privileges pending the appeal. All other penalties shall be suspended pending the appeal. Appeals shall be heard at the next Annual Meeting at a session attended only by voting members and the necessary secretarial staff selected by the President. The member shall have the right to be heard and to be represented. If two-thirds of those present vote by secret written ballot to reverse the Board's action, the complaint shall be dismissed.

NOTE—Alternate IV. Appeal Procedure

If the defendant or complainant appeals within 30 days after notification of the action of the district branch, the national Ethics Committee proceeds as in III above, and in addition reviews the procedure of the district branch. The final appeal may be to the general membership.

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)




ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)
DIRECTOR (CH-D)
Mr. Ted Wood 8606
DEPUTY DIRECTOR (CH-DD)
CAPT TANNER, USN, 8606
OFFICE OF LIAISON ACTIVITIES (CH-LA)
LCDR BRUHN, 8904
SPECIAL ASSISTANT FOR BENEFICIARY AFFAIRS (CH-SA)
MR. [illegible], 3739
OFFICE OF GENERAL COUNSEL (CH-GC)
MR. SEAMAN, 8506
OFFICE OF APPEALS AND HEARINGS (CH-AH)
MR. WORTHEY, 8204
PROGRAM PLANNING AND POLICY DIVISION (CH-PP)
MR. RHEA, 8608
PROGRAM PLANNING BRANCH (CH-PL)
PROGRAM POLICY BRANCH (CH-PO)
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MR. HUDSON, 3801
BUDGET AND ACCOUNTING BRANCH (CH-BA)
MR. FISCHTHAL, 3801
REIMBURSEMENT BRANCH (CH-RB)
MR. ISAACSON, 8082
MANAGEMENT ANALYSIS BRANCH (CH-MA)
MR. BAILEY, 8904
PROGRAM OPERATIONS DIVISION (CH-OP)
MR. GRAZIANO, 8609
BENEFIT AUTHORIZATION BRANCH (CH-BO)
MRS. EASLEY, 8526
RECONSIDERATION BRANCH (CH-RC)
MR. FREY, 8526
CONTRACT OPERATIONS BRANCH (CH-CO)
MR. GALLEGOS, 8527
BENEFIT SERVICES BRANCH (CH-BS)
MR. KOLB, 8808
PROGRAM EVALUATION DIVISION (CH-PE)
MR. HAMMER, 8806
EVALUATION BRANCH (CH-EB)
MR. RUBIN, 8806
STATISTICS BRANCH (CH-ST)
MR. [illegible], 8043
QUALITY ASSURANCE BRANCH (CH-QA)
DR. HOFFMAN, USAF, MC, 3713
CONTRACTOR PERFORMANCE EVALUATION BRANCH (CH-CP)
MR. LONG, 8806
ADMINISTRATIVE SUPPORT DIVISION (CH-AS)
MR. RE, 8607
SUPPORT SERVICES BRANCH (CH-SS)
MRS. PULEO, 8663/8800
WORD PROCESSING BRANCH (CH-WP)
MRS. HALL, 8469
PROCUREMENT BRANCH (CH-PC)
MR. CURRAN, 8082
PERSONNEL BRANCH (CH-PER)
MR. NETTERFIELD, 8800

Telephonic Survey of the Recent Champus Experience of Local Hospitals in the Washington, D.C. area:

1. Hospital #1: Deposits:

AD	140
Adult open ward	$1550
Adolescent	1850
Child	2100
Closed Ward	2600
Alcohol	1300

Comments: "Extremely slow" "3 months behind in payments." "Not uncommon to lose claims -and after many calls to Roanoke--they would ask us to submit duplicate claims--this has happened at one point in about 45% of our claims."
"Most insurance companies pay in 30-45 days after submission of claim."
"Payments from CHAMPUS are often incorrect--either over or under payment with no rhyme or reason."
"It costs our hospital money not to have claims processed effciciently."
"We don't have guidelines for CHAMPUS."

2. Hospital #2:

Comments: No deposit if insured. "No problem with payments." Eight to twelve weeks delay after submission of claim but of no concern to business office.

3. Hospital #3:

Comments: No deposit required if person has insurance. Recently many claims they have submitted are being returned for many reasons (50%). Claims are paid 1-2 months after submission. Generally no problems felt with CHAMPUS.

4. Hospital #4: Deposits:

AD	None
Retired	$600

Comments: "We do have problems with them."
"They (CHAMPUS or Blue Cross of Maryland in Baltimore) often have trouble in identifying persons."

Telephonic Survey of the Recent Champus Experience of Local Hospitals in the Washington, D.C. area:

4. Hospital #4 (continued)

Comments: "There are occasional loss of claims and delays in making payments--2 months+." Normally insurance company makes payment within 30 days after submission of claim.
Another problem is "no one to call who is in charge" "30% of claims are significantly delayed or returned."

5. Hospital #5:

Comments: No deposit required if insured.
"Don't do that much business with CHAMPUS."
"Takes 60-90 days if lucky to receive payment after submission of claim."
They promised a Handbook a year ago--haven't received it.

6. Hospital #6:

Comments: No deposit for AD or retired.
No problem with CHAMPUS.

7. Hospital #7: Deposits: AD $ 100
Retired 4209

Comments: They file monthly--hardly no denials.
They have claims processed in one month.
Not dissatisfied with CHAMPUS.

8. Hospital #8: Deposits: required for retired: $200-300.

Comments: Blue Cross in Maryland has been behind 2-3 months--which causes a problem in tieing up cash flow.

DEPARTMENT OF THE ARMY
FITZSIMONS ARMY MEDICAL CENTER
DENVER, COLORADO 80240

30 March 1979

A-10

Terry E. Gagon
[illegible]
Mclean, VA 22102

I have completed a phone survey of the five area hospitals we are most likely t refer dependents and retired to for admission in the Denver area. They exclude some fine residential programs that are not qualified for or refuse to request qualifications for CHAMPUS funding. Two of the hospitals are general private hospitals with all other services and neither reported differential slowdowns in payment for patients [illegible] versus other services. All information was collected with the guarantee of anonymity as to the hospit , however, no one had refused or hesitated to cooperate in answering questions prior to being given information.

No practitioner on any hospital staff refused to accept CHAMPUS patients although most are unhappy with the 75-85% reimbursement by CHAMPUS. None of the hospitals refused to accept CHAMPUS patients except the residential programs as above and only one requires a deposit; a deposit covering the deductible for the projected length of stay is required of all patients when a third party payer is involved. One hospital was audited by a GSA auditor on behalf of CHAMPUS - the majority of their "charity" cases related to CHAMPUS beneficiaries who could not pay their 20-25%. That hospital has a committee to determine such hardship cases and works to find auxiliary funding in the community.

Only one hospital reported a cash flow problem and that was six months ago. The majority of hospitals report such a low percentage of CHAMPUS cases that the delay in payment has little effect on their cash flow.

The delays in payment are increasing and range from as low as 60 days to well over 90 days with the usual range reported to be 60 to 90 days. This contrast to the "Blues" who generally pay within 15 to 45 days except at one hospital where the "Blues" are reported as "no better than CHAMPUS". The general consensus is that the delays are getting longer. One hospital reported a good deal of delay was caused by their own inefficiency in processing claims, but one reported difficulty in determining what is required on the CHAMPUS forms despite years of experience with this system. They often feel as if they're trying to outguess some clerk in the fiscal intermediary office. The common complaint was that the forms would be returned in the 60 to 90 day period with requests for more information--it seemed to the reporters an excessive delay in asking for further information to be followed by further delay in processing the claim. Three hospitals complained of lack of a toll free line to the fiscal intermediary stating that phone calls were often necessary to iron out problems and were very expensive.

ADDRESS ALL COMMUNICATIONS TO THE COMMANDER
FITZSIMONS ARMY MEDICAL CENTER

One hospital seems to have a very difficult time obtaining nonavailability statements. Another is concerned about problems related to a patient refusing to give them his "CHAMPUS card" and the legality of making copies of these as requested by the Fiscal Intermediary.

One hospital recommended a mandatory supplemental insurance program for retired and perhaps active duty as well to cover the 20-25% deductible.

A need for guidelines and someone to turn to were identified as needs along with the toll free phone line.

Arbitrary limits which leave some patients only partially treated when the family cannot or will not continue therapy after the end of CHAMPUS benefits often results in massive waste as the treatment gains are lost following discharge from the hospital.

Ex post facto refusal to pay was not identified as a major issue.

From the GSA auditors' report at one hospital it was found that there seems to be a lack of intermediate care facility resulting in very expensive hospital treatment or no treatment at all for some patients--especially adolescents.

Lastly, most hospitals are and expect to continue to be willing to accept CHAMPUS patients as when payment is made, it is usually correct, and most hospitals feel certain that they will be paid eventually. This was the only positive statement made by any of the hospitals.

Hopefully, this fits well with your own findings and will support the notion of a widespread problem rather than one confined to the DC area. If I can be of any further assistance, please give me a call or drop a line.

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TASK GROUP 6

WOMEN IN THE ARMY

Group Members:

LTC Jesse J. Harris, D.S.W., Team Leader
COL Bob Nichols, Ph.D.
1LT Mike Spradlin, M.S.W.

SOLE PARENTHOOD FAMILIES

(Change 9 AR-600-20)

Sole parenthood is a fact of life in the United States doday. More than ever before the United States Army reflects what appears to be a representative sample of the work force. Therefore the Army will have an increasing number of sole parents. If the Army is to accept sole parents as part of it's uniformed family it must be aware that this is a population at risk. Events may occur in the "good" soldiers' family life that renders the best thought out family plan useless, i.e. illness of child.

Military life and operations create special stresses for military families. Therefore military support services must be available to them in order to maintain an effective fighting force. Based upon the above assumptions the task force recommends the following:

1. That behavioral scientists become aware of regulations, restrictions, resources and problems facing the sole parent in the Army.

2. That behavioral scientists make the commanders aware of existing resources which are available for sole parent families in case of military emergency. (to include their limitations)

3. That behavioral scientists make recommendations to commanders of additional support requirements needed for sole parent families in case of emergency.

4. Individual counselling should be made available to sole parents by professionals.

5. Emergency child care must be made available. This may include 24 hour, seven day a week care in some cases.

6. Constitute a task force to address in depth the impact of military life on the child of the sole parent family.

7. That a determination be made to answer the question: Who has ultimate responsibility regarding child welfare, the Army or the parent?

ABORTION

As the number of women soldiers increase it can be expected that the number of pregnancies and abortions will increase. In order to maintain an effective fighting force it is recommended that the Surgeon General accept the following recommendations:

1. That the statute affecting abortions in military hospitals be amended to provide for abortions on demand for all military women on active duty.

Rational.

a. The increasing pregnancy rate (12% in 1976 to 15% in 1977) suggest that an increasing number of women will desire and seek termination of their pregnancy.

b. It will reduce the attrition rate of trained personnel.

c. It may reduce the increasing rate of sole parent families.

d. It should have a positive effect with respect to deployability.

e. It is more equitable with respect to gender treatments.

2. Provide abortion on demand for all personnel (military and dependents) in isolated areas or where abortions are not otherwise available.

INTEGRATED UNITS

Behavioral scientists must assure that Commanders are aware of the following areas which are believed to impact negatively on unit effectiveness:

1. Fraternization (especially cadre with trainees).

2. Physical differences and capabilities between male soldiers and female soldiers.

3. Differences in illness behavior patterns.

4. Attitudinal differences with respect to task given.

5. Differences in male and female expectations with respect to what Army life is all about.

6. Intellectual and age differences; women scoring higher on GT tests and being older than the average male at entry.

7. Differences in socialization between male and female prior to entry into service.

8. Differences in clothing requirements especially field clothing.

9. Differences in equipment requirement and fit.

10. Differences in requirements for physical security especially in the billets.

These differences which are found or suspected between male soldiers and female soldiers should not be considered as permanent, especially those in attitude and capability. Indeed there will be as wide a variability

among females as we find among males. Commanders should be made aware that there will be more similarity between the genders than differences. However, where differences are expected to exist, programs should be available to modify those differences when they are cost effective, or to teach commanders to capitalize on those differences when they are cost effective. In addition, Commanders should be aware of the possibility for favoritism based on gender and should as far as possible strive for a staff of support personnel whose ratio is similar to that of the target population.

WOMEN IN COMBAT

Recommendation:

1. That Department of the Army create a research team comprised of behavioral scientists to include those who are combat experienced to study the question of the psychological and sociological factors impacting on the effectiveness of women in combat.

2. If the above recommendation is not feasible, task the Academy of Health Sciences, Health Care Studies Division, to conduct a literature search and present its conclusions.

FRATERNIZATION
(AR 600-20)

Recommendation:

Support the broad language of a recent DA message, Subject: Relationship Among Superiors and Subordinates.

TASK GROUP 7: LEGAL ISSUES PERTAINING TO INVOLUNTARY HOSPITALIZATION OF MILITARY PERSONNEL

Group Members:

Albert A. Kopp, COL, MC
William F. Schultheis, LTC, MC
Glen Olson, CPT, MS
Robert Heffer, CPT, MS

JUSTIFICATIONS FOR PROPOSED REVISIONS OF AR 40-3 AND AR 600-20

The present AR 40-3 contains mistakes and does not reflect current therapeutic
nking and intervention. It is also to be noted that the present regulation
the potential of placing a Hospital Commander in a compromising position.

Present antiquated terminology and aspects, such as use of "closed wards",
s been replaced with more generally meaningful and therapeutic aspects.

. Revision of Paragraphs 2-7, AR 40-3, gives authority to involuntarily
ospitalize a patient. ("Closed ward" omitted in present regulation.)

4. Current activist trends in Civil Rights necessitate that the regulation
should be changed to allow adequate and competent medical treatment.

5. Revisions provide protection to the individual patient by emphasizing the
individual treatment plan and flexibility of treatment.

AR 40-3, Paragraphs 2-7 (Proposed Revision)

Patients will be admitted for psychiatric inpatient evaluation and treatment under restrictions when they demonstrate the signs and symptoms of a psychiatric disorder that renders them dangerous to self or others and to alleviate undue emotional suffering.

They are also to be admitted for the purpose of careful and close psychiatric observation to determine whether such conditions do exist.

The reason for admission must be clearly stated in the clinical record.

The patient will be provided with an individualized treatment plan which will assure the minimal degree of restriction and involuntary care considered medically indicated for the condition.

d. Hospitalization when competent therapeutic care and supervision is necessary to achieve protection of the patient or others from harm. This determination will be made by the psychiatrist. In the absence of a psychiatrist, the attending physician with consultation from the designated mental health professional (Social Work Officer, Clinical Psychologist, Clinical Nurse Specialist/Clinical Nurse Practitioner) will determine the level of involuntary care required while adhering to the policy of least restrictive care necessary in that individual patient's case.

e. (Specifically revised to avoid definition of incompetence with its probable legal entanglements.)

Medical care related to mental disorders, the symptoms of which as determined by a Medical Board severely compromise the patient's ability to cope rationally, effectively, and safely with the demands of their environment to include the treatment setting.

TASK GROUP 8

Sexual Variants and Deviations in the Army

This task force presented the complicated problem of combining psychiatric knowledge, attitudes of society, official DA stances, and legal pressures to evolve changes in regulations of sexual deviations.

The current regulations prescribe differences in the treatment of officers and enlisted people as to who should do the mental status evaluation, responses if overt homosexual behavior has occurred, and the problem of homosexual tendencies without overt acts.

One question raised in current court cases such as Matlevich and Berg is what the individual's quality of service and also usefulness to the service has been. One of the standard arguments against retaining homosexuals in the military has been that they present security risk. The majority of evidence, however, that servicemen with large debts or who are alcoholic are the greatest security risks.

In formulating recommendations for regulations, the main consideration was the degree of harmfulness to others. These were mainly grouped into harmful sexual behaviors, such as sexual acts with children, rape, intimidation of others in barracks or units, and sadomasochism. An intermediate group of nuisance acts includes exhibitionism, voyeurism, and obscene phone calls. The third group, which don't seem to harm others includes mutually homosexual acts in private, fetishism, transsexual, and transvestitism.

Transsexualism seems to fall in a unique category and is difficult to categorize in Army regulations. It could best be subsumed in AR 40-501 induction standards with requirements for a psychological and medical evaluation for fitness for indiction. Transsexuals should be evaluated on an individual basis because of current controversial data on psychological health of transsexuals, higher degree of psychosis and suicide, medical and surgical requirements and complications, and possible effects on unit morale. The courts are currently struggling with the issues of marriage to a transsexual, legal rights, and ability to adopt children.

The regulations covering homosexuality are 635-200 for enlisted men and 635-100 for officers. It was generally the task force opinion that officers and enlisted regulations be the same. It is currently unclear whether homosexuality is a medical diagnosis since the change in 1975 in DSMII by the APA. The Army regulations (635-200, Chap 1-30) calls for medical evaluation by a mental health workers, with referral to a psychiatrist if indicated. This still sounds appropriate for both categories of personnel. Chapter 13-42 which addresses unsuitability should be amended to read "Overt homosexual acts or other sexual variations (including, but not limited to transvestitism, fetishism, voyeurism, exhibitionism) which are shown to be detrimental to

member's ability to perform duty." The regulation pertaining to misconduct (635-200, Chapt 14-33) should not include homosexuality, which would be covered in Chapter 13. Chapter 14-33 should include the following: "(a) Acts of misconduct including sexual behavior considered harmful to individuals or group other than the person performing the act, including: (1) Indecent acts with or assault upon a child (2) Rape, (3) Indecent exposure, (4) other indecent acts of offenses." It is suggested that terms such as "lewd and lascivious acts" and "sodomy" are open to wide and imprecise interpretation, and should probably be omitted.

Finally there are several useful studies that should be examined to see if they are relevant. These include the JAG NATO Study concerning the handling by NATO allies of homosexual soldiers, Dr. Grass' study at Harvard of WW II homosexual officers, Federal Civil Service policies, and recent court decisions.

The area of treatment of sexual disorders should also not be neglected. In psychiatric residency programs and 91G school should specifically have classes on psychotherapy and other treatment techniques for sexual malfunctions.

Further research might also be undertaken to assess attitudes, etc., before changes in the regulations are made.

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LTC, MC
Assistant Chief
Psychiatry Inpatient Service

Valedictory: Response to the Task Groups (Leadership)

COL Franklin D. Jones, MD

Psychiatry and Neurology Consultant

Office of The Surgeon General

Washington, DC 20310

Colleagues:

Through no particular fault of my own I have fallen into the legions of what my predecessor, Jim Rumbaugh, calls the "ledgerers of legumes" or more prosaically "bean counters." With this thought in mind I experienced a certain uneasiness when I noted the silence which greeted the announcement that I would be speaking instead of General Hank Mendez. Personally knowing General Mendez, in my narcissism, I did not feel an explanation for his absence to be necessary, but it occurred to me later that many of you don't know him and might misunderstand. As soon as General Mendez knew that he might not be able to attend, he called me. In the ensuing day he made valiant efforts to escape the clutches of a budget committee. When it became obvious that he could not come, he explored whether General Pixley might do so, but he was also captive to legislative demands.

The moral of this vignette is that Colonels have more freedom than Generals. This brings us to the area of leadership.

One of the essential attributes of a leader is that he must be viewed by his constituents as parochial to their interests. Another essential attribute is that he must be truly parochial only to the accomplishment of the mission. A successful leader is one who can clearly differentiate these interests, act in the interests of the mission and still maintain credibility.

I have heard, and probably made, many parochial comments at this meeting; but, most hearteningly, I have observed many successful leaders in action -- leaders who have been successful because they have put the mission first. The mission has remained the same since the inauguration of the now renamed Medical Field Service School: "To conserve the fighting strength."

To conserve that strength we have addressed a number of issues.

Some issues have dealt with our relations to each other. We cannot improve the morale of our charges and thus reduce ineffectiveness if we ourselves are demoralized. We therefore owe it to them to be self-insightful, to monitor our attitudes and to insure that our feeling of well-being is based on our value in accomplishing the mission, our productivity in the effort rather than fleeting and insubstantial issues of status or neurotic needs for control and self-aggrandizement.

In this regard we have discussed educational programs aimed partly at

helping us distinguish ourselves from each other but mainly aimed at improving our competency to help the patient.

In these areas, where our parochial interests weigh heaviest, we have experienced the greatest amount of dissension, the greatest disunity. Perhaps we have failed to be guided by our second principle of fidelity first to the mission.

Some issues have dealt with our relations to other agencies. Particularly we have examined non-military mental health care brokers or funding agencies (that is, CHAMPUS) and those guardians of the dark sides of our own natures, the law-givers, who have put down in black and white the categories of persons who should receive our ministering, persons whom we should spurn, and persons who may spurn our ministrations.

Examination of the CHAMPUS situation has resulted in the recognition that military dependents are sometimes being denied psychiatric care because of administrative delays in processing claims. These delays have resulted from the need to validate the eligibility of the claimant, from the APA-CHAMPUS 100 percent peer review procedures, and, we suspect, from a bias concerning the legitimacy of psychiatric and psychological services. OCHAMPUS apparently does not know within two million persons, the dependents eligible for care. We were told that

the number is from six to eight million.

An examination of regulations concerning the involuntary psychiatric hospitalization of active duty personnel (AR 600-20, chap. 5, Sec IV) reveals that this can be done when the "life or well-being" of a service member is endangered. This regulation needs modification in terms of including the military mission as a factor.

In these areas where our parochial interests are less threatened, we have achieved greater harmony.

Some issues, happily the majority, have dealt with our relations to the patient himself, the object of our concern. We have discussed how we can identify and intervene in behalf of the problem drinkers or the self-prescribing drug abuser. We studied the emerging concerns of and about women in the Army, the morality involved in forcing women to choose between procreation and careers and the subtle but tangible damage to our fantasies caused by a new awareness of competition between the sexes in the Army job market and ultimately, perhaps, in battle. We have attempted to objectify in terms of its relevance to the soldier's mission the presence of sexual behaviors which range from the annoying to the dangerous.

The celebrated Matlovich and Berg cases in which an exemplary Air Force technical sergeant, Matlovich, and a Navy ensign, Berg, announced their

homosexuality and were administratively seperated, has resurfaced in the appeal process. The judge determined that a military member may not be separated soley on the basis of homosexuality but rather the burden of proof lies with the military to show how the homosexuality interferes with duty. Traditionally homosexuals have been excluded on the basis that this is considered mental illness, that they represent security risks, and that they would be disruptive to small unit interactions, producing demoralization. The APA decision to include homosexuality as a psychiatric disorder only when the patient experiences it as a conflict, i.e., sexual orientation disturbance and the observation that more heterosexuals involved in love affairs have been security risks than homosexuals have raised serious objections as to the validity of the first two bases for exclusion. The unit disruption argument may hold up, particularly in basic training settings in which "late adolescent" soldiers whose sexual identity may not be solidified might be threatened.

In these areas of least threat to our parochial interests and greatest relevance to the accomplishment of the mission, we have reached near unanimity.

Obviously all of us will have to search our souls on the issues of greatest parochial interest, those having to do with our relations to each other. We have had in the current organization, spelled out in AR

40-216, two decades of traditional experience and a few years of experimentation. We have proposals for further experimentation from the occupational therapists. We can examine our data base and draw conclusions but we must try to determine whether our policies or external social conditions account for the results. Let me exemplify. We have an excess of social workers, a slight shortage of psychologists, and a disastrous shortage of psychiatrists. I would doubt that these conditions have anything at all to do with our relations to each other but rather they seem to be shaped by simple financial contingencies. To attack this problem it would therefore profit a personnel manager to expend his energies more on gaining control of the financial contingencies than in examining our relations to each other.

Another exemplifying set of data relates to the increasing numbers of inappropriate hospital admissions to Walter Reed Army Medical Center from regional posts manned by non-psychiatrists or by marginally competent psychiatrists. Although the situation develops from the financial contingencies previously mentioned, they also relate to our relations among ourselves. We have in this situation a natural experiment from which data should be collected. Will the data show us that there are more misadmissions from posts with marginal psychiatrists or from posts with no psychiatrists? The results of such data collection, if they could somehow be made comparable, might help us in knowing when

to assign a non-psychiatrist as chief of a CMHA.

I wish on behalf of The Surgeon General to thank the command and staff of FAMC for an outstanding record of support and each of you for your dedicated efforts in the tasks.

It is now the mission of the final task force, composed of the consultants, to take your productions, measure them against the yardstick of mission accomplishment, and advise The Army Surgeon General as to what actions should be taken and this we will do.

SINGLE-PARENT FAMILY: ACTIVE DUTY AND DEPENDENT

BY

CAPTAIN ROBERT H. GEMMILL

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ADDENDUM

"There is nothing permanent except change."

Rogers: Student's History of Philosophy

The attached paper entitled, "Single-Parent Family: Active Duty and Dependent," was presented at the U. S. Army Social Work Symposium in March 1978. Part of the paper addressed the sole parent in regard to voluntary separation and counseling. Since that time, there have been a number of changes to Army Regulations, which pertain to sole parents.

The most current change is reflected in DA Pamphlet 600-8, Interim Change, No. 101, which supplements AR 600-20 and AR 614-30. The change addresses sole parents and married Army service couples with dependents.

DA Pamphlet 600-8, Interim Change, No. 101 states:

All officer sole parents with less than 3 years active Federal service and all enlisted sole parents regardless of grade in the categories listed below must be counseled regarding their responsibilities to the service. Additionally, enlisted sole parents will be required to submit a dependent care plan to the unit commander which will be forwarded through command channels to the approving authority for evaluation and disposition.

a. Army members who are married to other service members and have minor dependents (under age 13).

b. Army members who are sole parents or sole guardians of minor dependents. This includes members having sole custody of dependents because of divorce, legal separation, because spouse is not residing permantly with member, or because spouse is not capable of self care.

c. Army members who are married to other service members and have responsibility for the care of dependents who are unable to provide for themselves (e.g., handicapped, infirm), regardless of age.

d. Army members who are sole parents or sole guardians as indicated in b above, of dependents who are unable to provide for themselves (e.g., handicapped, infirm), regardless of age.

Commanders are required to:

a. Identify members of their command who have dependents as indicated above.

b. Counsel members regarding members' rights and entitlements, responsibilities to the Service, and their responsibilities for the care and welfare of dependents. Additionally --

(1) Enlisted members will be counseled regarding the involuntary separation provisions in paragraph 5-34, AR 635-200, which should be invoked whenever parenthood interfers with military responsibilities.

(2) Enlisted members will be counseled regarding the provisions of paragraphs 1-34c and 1-34d(14), AR 601-280 for bars to reenlistment for failure to provide an approved Dependent Care Plan or for failure to manage family affairs.

(3) Officers will be counseled regarding the provisions of section XV, chapter 3 and section IV, chapter 5, AR 635-100, and chapter 4, AR 635-120.

Changes in Army Regulations pertaining to sole parents are presently reflected within four management tools. The four management tools are: (1) counseling, (2) reenlistment control, (3) performance appraisals, and (4) involuntary separation.

The present changes in the management tools are described in an unclassified message dated 24 Nov 78, subject: Resolution of Sole Parent Problems. The message states that "Secretary Alexander has approved changes to Army Regulations which will give commanders more flexibility in resolving sole parent problems." The changes will be effective January 1979.

The changes are as follows:

1. Counseling: Previous policy required commanders to counsel sole parents and in-service parents with less than 3 years' service. This will be expanded to include all enlisted sole parents.

2. Reenlistment Control: AR 601-280 permits a bar to reenlistment for failure to manage personal, marital, or family affairs. An explanation will be added to specify that this includes failure to respond to duty requirements because of parenthood. The new policy will also require that a bar to reenlistment be imposed on any soldier who does not provide his commander an acceptable dependent care plan.

3. Performance Appraisals: If a service member's duty performance is impaired because of parenthood, this will be clearly indicated in the individual's performance appraisal.

4. Involuntary Separation: There will be family emergencies when it may be appropriate to excuse a service member from duty, and there are provisions in policy to accommodate extreme family problems. However, when it is evident that a service member, either officer or enlisted, is unable to perform prescribed duties, is repeatedly absent from work or is not available for worldwide assignment because of parenthood, that service member will be involuntarily separated UP AR 635-100 or 635-200.

PREFACE

> "Civilization varies with the family, and the family with civilization. Its highest and most complete realization is found where enlightened Christianity prevails; where woman is exalted to her true and lofty place as equal with the man; where husband and wife are one in honor, influence, and affection, and where children are a common bond of care and love. -This is the idea of a perfect family."
>
> W. Aikman

The traditional image of a family consists of a husband, wife and their children living together in a house. This is a traditional, favorite and comfortable concept, because a substantial majority of families are husband-wife-children families. Yet, there is a non-traditional family structure that is growing faster than two-parent families - the alternative family structure or often referred to as the "single-parent family".

Stuart and Abt (1972) indicate that there are "presently three million American families with eight million children that constitute one-parent families." According to Ross and Sawhill (1975) over the past ten years female-headed families with children have increased ten times as fast as two-parent families. They also indicated that by the mid-1970's one out of every seven children in the U.S. lived in a family where the father was absent. According to data presented in popular magazines, based on the latest census bureau data and information from other governmental agencies as of 1977, there were 7.2 million families, one in every

eight, headed by a female.

Based on 1970 census figures (U.S. Department of Commerce, 1970) approximately 1,382,454 children live in single-parent households headed by their fathers. An estimated 601,038 divorced, separated, widowed or never married fathers are rearing these children alone. The number of children being reared by fathers in single-parent families increased by more than 100 per cent during the decade between 1960 and 1970 (U.S. Department of Commerce, 1960 and 1970).

It seems apparent, from the above data, that an alternative family structure has emerged and is on the increase in the United States. If the growth of the alternative family structure continues, it may soon be identified as the "other traditional family structure".

The military has been described as a reflection of the larger society. If this description is correct, then it is reasonable to infer that the alternative family structure exists in the military and is on the increase.

INTRODUCTION

I have been requested to address the subject: The Single-Parent Family - Active Duty and Dependent. This presentation is to be provided from a pragmatic experiential view, as opposed to a theoretical perspective.

This paper will be divided into five parts: First, problems encountered with definitions of the alternative family structure; second, research and theoretical disarray; third, state of military research or significant uncertainity; fourth, problems facing the social worker in dealing with unwed adolescence pregnancies; and fifth, eight lessons learned from personal experience.

Defining the Alternative Family Structure

> "When I use a word," Humpty Dumpty said, in rather a scornful tone, "it means just what I choose it to mean-neither more nor less."
> "The question is", said Alice, "whether you can make words mean so many different things."
> "The question is", said Humpty Dumpty, "which is to be master-that's all."
>
> Lewis Carroll

The phrase "single-parent family" is often used synonymously with alternative family structure. The phrase is also commonly used as a self-descriptive term to interpret the meaning of the alternative family structure. This places a great deal of responsibility on the interpretative qualities of the user and the term. Lewis Carroll inferred that some words are overpacked with interpretations and meanings, when two of his famous characters stated, "That's a great deal to make one word mean," Alice said in a thoughtful tone. "When I make a word do a lot of work like that,"

said Humpty Dumpty, "I always pay it extra."

Kaseman (1974) defines the single-parent family as the "core unit in which one parent is no longer present, owing to death, divorce, no marriage, or illness." AR 635-200, Chapter 6, dated 21 November 1977 addresses the sole parent and states "Service members who are sole parents, and whose child or children under 18 years of age reside within the household, may apply for discharge under hardship. A 'sole parent' is defined as a parent who is single by reason of never having been married, or is divorced, or is a widow/widower." A composit definition, formulated from a variety of authors (Freudenthal, 1959; Stuart and Abt, 1972; Weiss, 1975; Ross and Sawhill, 1975; and Mendes, 1976), indicates that a "single-parent family is a male or female headed family unit, consisting of one or more children that are physically living with one or both of the parents."

The above definition is useful for general discussion, but it is inadequate for any investigative purposes or therapeutic invention. There exists within the phrase and the definition the inaccurate assumption and the false sense of security that we know what we are talking about. The phrase "single-parent family" may also be offensive to some people, since it once was, and may still be, an euphemism for "unwed mother" and congers up apparitions of immorality, and repentence. The phrase is also suggestive of deviant and dysfunctional behavior. It is assumed that the husband-wife-child family structure is the "normal model" or "best model" which serves as the norm by which other family structures can be evaluated (Thomas and Sillen, 1972). It may also be assumed, that the "single-parent

family" is a "tangle of pathology" which produces predictable dysfunctional consequences.

Terms and general definitions that attempt to represent or describe the alternative family structure present problems for a number of reasons.

First, there are an array of terms that fragment the subject, without fully describing the components of the alternative family structure. A number of these terms include:

1. Beyond Divorced Individuals
2. Formerly Married
3. Fatherless Homes
4. Female Headed Families
5. Male Headed Families
6. Never-Married People
7. Never-Married Fathers
8. Never-Married Mothers
9. One-Parent Family
10. Parents Without Partners
11. Single Fatherhood
12. Single Motherhood
13. Single Parents
14. Single Parent Family
15. Sole Families
16. Solo Families

Second, the alternative family structure is a dynamic family organization that is configured in different ways at different times. Terms and general definitions do not make visible, the invisible structure of the family organization. For example, in regard to the "single-parent family" all or part of the children may not be physically present in the home. In addition, a child may mature into an adult and still be living in the home for a number of reasons. Another example is the "female headed family", which may consist of a mother and her children or two sisters living together.

Third, terms and general definitions do not address the process by which alternative family structures come into existence, evolve into other living arrangements or cease to exist. This process is often traumatic, unpredictable and unplanned. The process is important for a number of reasons, which includes understanding family dynamics, social dysfunction, survival techniques, medical needs, psychological needs and financial needs. It is also important for accessing intervention techniques and the level of self-image of the family members.

The alternative family structure may come into existence due to imposed or non-imposed separation, divorce, death, illegitimate children, adoption, separate households, illness or long-term institutionalization. The same family structure may cease to exist due to remarriage, reconciliation, departure of family members, death or uniting with other families (put together families). It should be noted that when the alternative family structure ceases to exist, the psychological trauma associated with its creation and existence may linger for years. It is also important to realize that the family structure may not have returned to a traditional family structure, but evolved into other living arrangements, such as the wife living alone. In these instances, rather than a reduction of psychological trauma there may be an increase.

Certainly, the alternative family structure can be adequately defined, but one must beware of verbal utterances without clear meanings. I hope that I have communicated that terms and definitions must be carefully selected and defined to adequately describe the target population, especially for research inquires and intervention techniques.

Research and Theoretical Disarray

"Order is a lovely thing;
On disarray it lays its wing,
Teaching simplicity to sing"

Anna Hempstead Branch

I would like to make a brief comment on the research and theoretical state of information pertaining to elements of the alternative family structure. Research in the field is diverse and conflictual. One is immediately immersed in a variety of subject areas which address various components of the alternative family structure, such as: sexuality, birth control, abortion, family planning, child development, public health, counseling, social work, religion, history, medicine, sociology, psychology, anthropology, administration, and business. The conflictual nature of the research is an expected reality, but it is unfortunate that almost any reasonable thesis, and some unreasonable, can be supported by the literature. It makes no difference if theories are in direct conflict of each other, support can be found for both contentions. The conflictual and changeable nature of research findings may be rationalized by realizing that "research results are the best thing to believe at the time and place."

The theoretical base of the alternative family structure is diffuse, concepts continue to proliferate and terminology is fluid. No one perspective has eminent domain, which is to be expected, due to the complex socio-medical components of the alternative family structure. For example, in regard to adolescent unwed pregnancies there are at least eight theoretical perspectives that attempt to explain the phenomena, which are:

1. Psychoanalytical perspective (Edin, 1954; Young, 1954; and Bernstein, 1971)

2. Psychological perspective (Pannor, 1971; Krammerer, 1969; and Wimperis, 1960)

3. Sociological and political perspective (Vincent, 1961; Liben, 1969 and Rains, 1971)

4. Medical, prevention and treatment perspective (Illegitimacy: Data and Findings for Prevention, Treatment, and Policy Formulation, 1965)

5. Demographic and ecological perspective (Yurdin, 1970 and Herzog, 1967)

6. Pathology and stress perspective (Bacon, 1974)

7. Moral and economic perspective

(Facts, Fallacies and Future - A Study of the ADC Program of Cook County, Illinois, 1960, and Illegitimacy and Its Impact on the ADC Program, 1960)

8. Anthropological perspective (Malinowski, 1964; and Mead, 1939)

In summary, the existing research results reflect the need for theoretical refinement and continued emperical research.

State of Military Research: Significant Uncertainity

"All that lies between the cradle and the grave is uncertain"

Seneca

Contact with various military agencies regarding the "military single-parent family", revealed six common responses. Not all these responses were directly related to the "military single-parent family".

First, there is an awareness that women are on the increase in the military, especially since 1972. This increase has initiated new problems and/or has surfaced problems not previously recognized.

Deputy Assistant Secretary of Defense (Equal Opportunity) M. Kathleen Carpenter publically announced to the Defense Advisory Committee on Women in the Services (DACOWITS) at its last meeting that the Services plan to almost double the number of enlisted women in the active force, as reported in The Stethoscope, Fitzsimons Army Medical Center, February 23, 1978. DASD Carpenter indicated that increasing the level of women from 5.5 per cent to 11 per cent by 1983 is what she considered a threshold number and not an upper limit. This would result in increasing the current number of 100,000 enlisted women to just under 200,000. She stated that "The May 1977 Study on the utilization of military women directed by Secretary of Defense Harold Brown, as well as other studies conducted in the same time frame by private institutions and Congress, all agree that women are cost effective and essential to the all volunteer force."

Second, the number of "military single-parent families" is unknown.

Third, there are a number of proposed data gathering studies to be implemented within the year by various branches of the military. These studies will be directed toward the "military single-parent family."

Fourth, an undetermined number of single and married female soldiers with children feel suspicious of the military, when they are asked if they have children. It seems that there is a feeling, by some, that a state of antagonistic cooperation exist between the institutions of the military and the family (Hill, 1976).

Fifth, administrative procedures exist to voluntarily or involuntarily separate women, who become pregnant, from the military (York, 1978). In the Army, voluntary separations are offered under AR 635-200, Chapter 8 (Personnel Separations - Enlisted Personnel), dated 1 March 1978, which supersedes AR 635-200, dated 15 July 1966 (no regulation presently exists for officers). AR 635-200 requires counseling, without coercion, and the signing of a statement by the pregnant soldier and selection of one of two options. The statement and options are as follows:

> Statement of Counseling: I affirm that I have been counseled by (Grade) (Name) _____ this date on all items on the attached counseling checklist and I understand my entitlements and responsibilities. I understand that if I elect discharge I will be entitled to medical care at government expense at a military medical treatment facility up to 6 weeks post-partum for the birth of my child and that I may remain on active duty until 30 days prior to expected date of delivery or latest date my physician will authorize me to travel, whichever is earlier. I also understand that should I remain on active duty I will be expected to fulfill the terms of my enlistment contract. If I elect to remain on active duty, I understand that I must remain available for unrestricted service on a worldwide basis when directed and that I will be afforded no special consideration in duty assignments or duty stations based on my status as a parent.
>
> Options:
>
> ____I elect discharge for reason of pregnancy UP Chapter 8, AR 635-200. I desire to remain on Active Duty until _____ (date is not later than 30 days prior to my expected date of delivery.)
>
> ____I elect to remain on Active Duty to fulfill the terms of my enlistment contract.

Involuntary separation is performed under AR 635-200 Chapter 5 (Separation for Convenience of the Government) dated 21 Nov 1977. Involuntary separations are initiated "because of inability to perform prescribed duties, repetitive absenteeism or nonavailability for worldwide assignment as a result of parenthood."

Sixth, there are many significant uncertainities (questions and policy issues) pertaining to the "military single-parent family" to be researched and addressed. These uncertainities center around the impact the military has on the single-parent and the impact the single-parent has on the military. Various unanswered questions include:

A. What is the actual number of "military single-parent families?"

B. How is the "military single-parent" to be utilized?

C. Should the "single-parent" be encouraged to join the military?

D. Should the military assume the responsibility of providing special services to the "single-parent family?"

E. Are children of the "military single-parent" at higher risk (child abuse, child neglect, parental deprivation, availability of pediatric medical care, availability of educational opportunities and social and psychological deprivation) than children of "civilian single-parents"?

F. Is there a significant amount of loss time to the mission of the military when the sponsor and dependent roles merge into one, such as with the "military single-parent"?

G. How is the dual responsibility dilemma to be addressed? The dilemma presents itself when the "military single-parent" is held equally responsible for the roles of soldier and parent.

H. What influence does military policy have on the abortion, relinquishment and retention rates?

I. What happens to the children of "military single-parents" if mobilization takes place?

Problems Facing the Social Worker in responding to Unwed Adolescent Pregnancies

"The biggest problem in the world could have been solved when it was small."

The Way of Life According to Laotzu

The alternative family structure is too complex and broad to discuss in a brief period. Therefore, I would like to address one component of that structure: problems encountered with adolescent unwed pregnancies, active duty and dependent.

The pregnant patient has three basic options in regard to her born or unborn child, these being: abortion, relinquishment or retention (keeping). Patients who desire to abort, usually contact social work service by telephone for referral information. The majority of pregnant adolescent patients who are unwed and desire to relinquish, keep or are uncertain what to do are physically seen at Social Work Service. Various problems are experienced working with adolescent pregnant patients who are unwed.

First, there is the problem of patient availability (Bemis, Diers and Sharpe, 1976) and availability of auxilary persons. My experience has been that the pregnant unwed adolescent usually presents herself late in her pregnancy for medical treatment and social work service. It is not uncommon for her first experience with clinic and social work services to be on the day of delivery. The reasons for the postponement of medical and social work services include: concealment of pregnancy, denial of pregnancy, unaware services were available or needed, afraid to seek services and procrastination of the inevitable decision to relinquish or to keep the child.

Once the patient is identified, availability problems may continue. The patient often experiences difficulties in keeping appointments due to the lack of transportation, school and work responsibilities and military duties. Once the patient delivers, there is a rapid termination from services.

It is unusual for the father of the child to be available. I have found that the patient's "boyfriend", if one exists is more often available than the father. The father may be unknown to the mother, or she may refuse to reveal his name, he may be physically on the run, afraid or embarrassed to present himself or the patient's father may not allow him to have contact with his daughter.

Auxilary persons are often not available due to the "secret of pregnancy". When the patient is a dependent, it is common for her mother to be aware of the pregnancy and supportive. The dependent's father is often unaware of the pregnancy, and the father of the child may not even be aware of the pregnancy. The parents of the father may be aware of the pregnancy, but they often refuse to take any responsibility in the decision-making process and may be entangled in legal action, due to the pregnancy, and desire to minimize their involvement. When the patient is active duty and decides to relinquish, her parents and her duty section are usually unaware of the pregnancy and the relinquishment. She seldom decides to keep the child, unless emotional and financial support is received from the father, boyfriend, her immediate family or if she is financially independent, which is rare.

The problem of [illegible] the intervention technique employed [illegible]. While crisis intervention is an [illegible] equilibrium to those experiencing [illegible] must be neglected due to the impact [illegible]

Second, there [illegible] of available resources. [illegible] tion or steriliza-tion is desir[illegible]. If relinquishment is [illegible] integrated and centralized resources [illegible] include counseling, [illegible], marital instruction, [illegible] vocational testing and tr[illegible] relinquishing parent can even [illegible].

If retention [illegible] from the immediate family, and [illegible] society. If these resources [illegible] sparse, fragmented and de[illegible]

It is interesting [illegible] relinquish than to keep [illegible] places the social worker [illegible] either unindates the patient wi[illegible] just to meet the bas[illegible]

Third, there is [illegible] on the part of the social worker [illegible] to counter-

transference, it is possible that the patient may receive intervention procedures that are not appropriate, and do not meet the patient's needs. The social worker must be aware of his or her own biases that could result in the needs of the social worker taking priority over the needs of the patient.

Fourth, there is the inappropriate and often unpredictable intervention by medical professionals, non-professionals and business professionals. Inappropriate interventions can strike swiftly and can result in acute and chronic complications. Examples of these interventions include: (a) a hospital non-professional confronting a patient with her "shameful behavior," after she decided to relinquish her child, (b) patients being contacted by medical professionals or business professionals requesting that the patient take their child out-of-state for adoption which may be accompanied by a significant financial payment to the patient and (c) biased "professional advice" offered by the professional medical staff. The biases of the staff are often transferred to the patient with skillful finess.

I have found that by preparing the patient for inappropriate and unpredictable interventions in a non-threatening manner (forwarned-forearmed) can minimize the effects of these interventions. In those cases, where the influence of these interventions cannot be minimized, learning to apologize well is useful.

Fifth, there is the issue if a male or female social worker should work with pregnant women. I have found that the gender of the worker is not the issue, it is the quality service provided that is important.

Eight lessons learned from personal experience

"Experience is the extract of suffering"

A. Helps

Following are a number of lessons that I have learned from working with unwed adolescent patients.

First, the unwed pregnancy can be a positive growth experience. The pregnancy and the decision to abort, relinquish or keep is often not as traumatic as one is predisposed to believe and does not lead to irreversible personality changes. If the social worker will set the proper atmosphere, and encourage growth to take place, the pregnancy and disposition decision can be a maturing constructive experience.

Second, the mother of the patient is often of crucial importance. She is available when no one else is and is the source of family resources. She is ultimately involved in the decision making process and is the one who supports the decision and makes it work. If she is excluded from the intervention process, she is only excluded in the mind of the social worker.

Third, follow-up services need to be offered to the pregnant patient. After the brief initial involvement of hospital personnel and the family, there exists the aftermath of termination and isolation. The patient is then alone and needs periodic assistance.

Fourth, don't be embarrassed to ask questions that are germain. The social worker must distinguish between voyeristic needs and intervention needs, but when information is legitimately needed it should be requested. Often the question has more potential for embarrassing the social worker than the patient.

Fifth, be specific when asking questions, don't assume or generalize.

Sixth, discover the nature of the secrets. Unwed pregnancies always involve keeping secrets from someone. Knowing the secrets assists in

understanding the dynamics of the pregnancy, the patient's family and avoids violation of confidences.

Seventh, do not restrict birth experiences. For example, allowing and encouraging a patient, who has elected to relinquish her child, to deliver by the Lamaze method may satisfy needs that cannot be relived or re-experienced.

Eighth, a multidisciplinary approach is more effective than a single approach. Suggested persons and agencies to be involved in a multi-disciplinary approach include:

A. Physician - Adolescent Medicine Service

B. Maternal and Child Social Work Officer

C. Nursing Supervisor for Maternal and Child Health

D. Community Health Nurse

E. Chaplain for Obstetrical Services

F. Head Nurse OB Clinic

G. Head Nurse Post-Partum

H. New Patient Nurse OB Clinic

I. Newborn Nursery Nurse Clinician

J. Head Nurse of Labor and Delivery

K. Civilian Social Service Agencies

L. Licensed Adoption Agencies

SUMMARY

The paper entitled, Single-Parent Family: Active Duty and Dependent, was divided into five areas.

First, problems encountered with definitions of the alternative family structure. Problems included the inability of terms to accurately describe the components of the alternative family structure, incapacity of terms to make visible the structure of the family organization and terms not identifying the process by which the alternative family structure comes into existence.

Second, research and theoretical disarray. It was indicated that research in the field was diverse and conflictual. The theoretical base of the alternative family structure was described as being diffuse, with terminology in a constant state of change and further confused by a proliferation of concepts.

Third, state of military research or significant uncertainity. Six common responses were discussed in regard to inquiries regarding the "military single-parent family".

Fourth, problems facing the social worker in dealing with unwed adolescent pregnancies. These problems included patient availability, abundance or dearth of available resources, countertransference, inappropriate and unpredictable interventions and gender of social worker.

Fifth, eight lessons learned from personal experience. These lessons were the positive growth experience of pregnancy, the crucial importance of the patient's mother, the need for follow-up services, the request for

legitimate information, the need to ask specific questions, the importance of discovering the secrets of pregnancy, the encouragement of normal birth experiences and the effectiveness of the multidisciplinary approach.

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